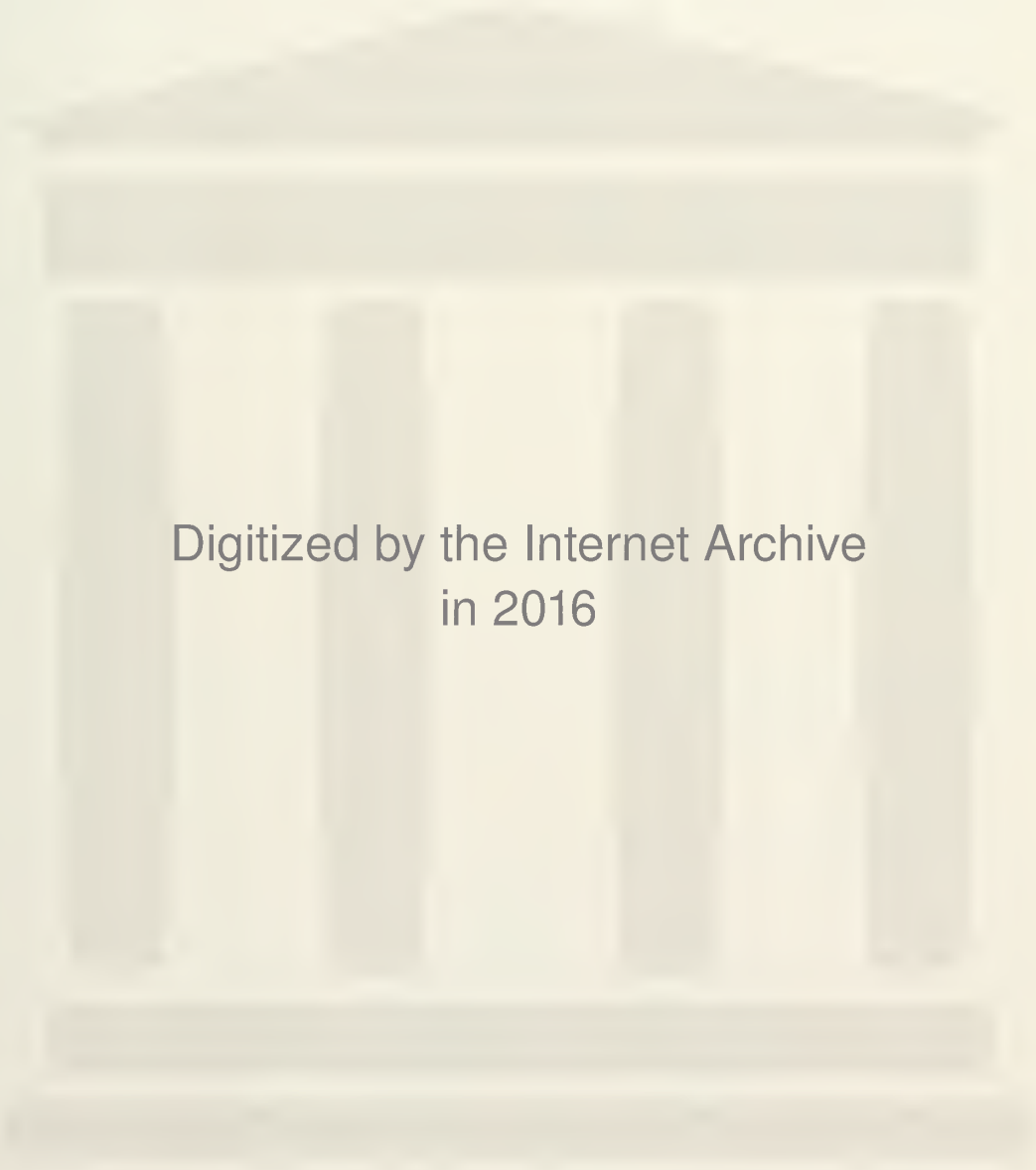
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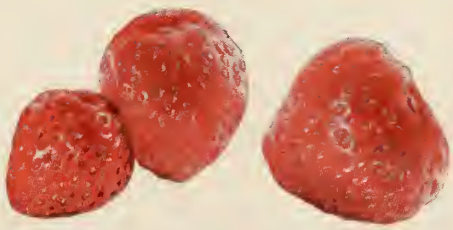
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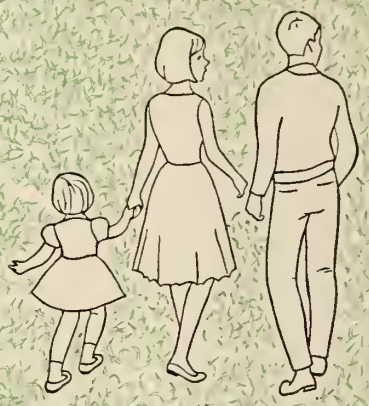
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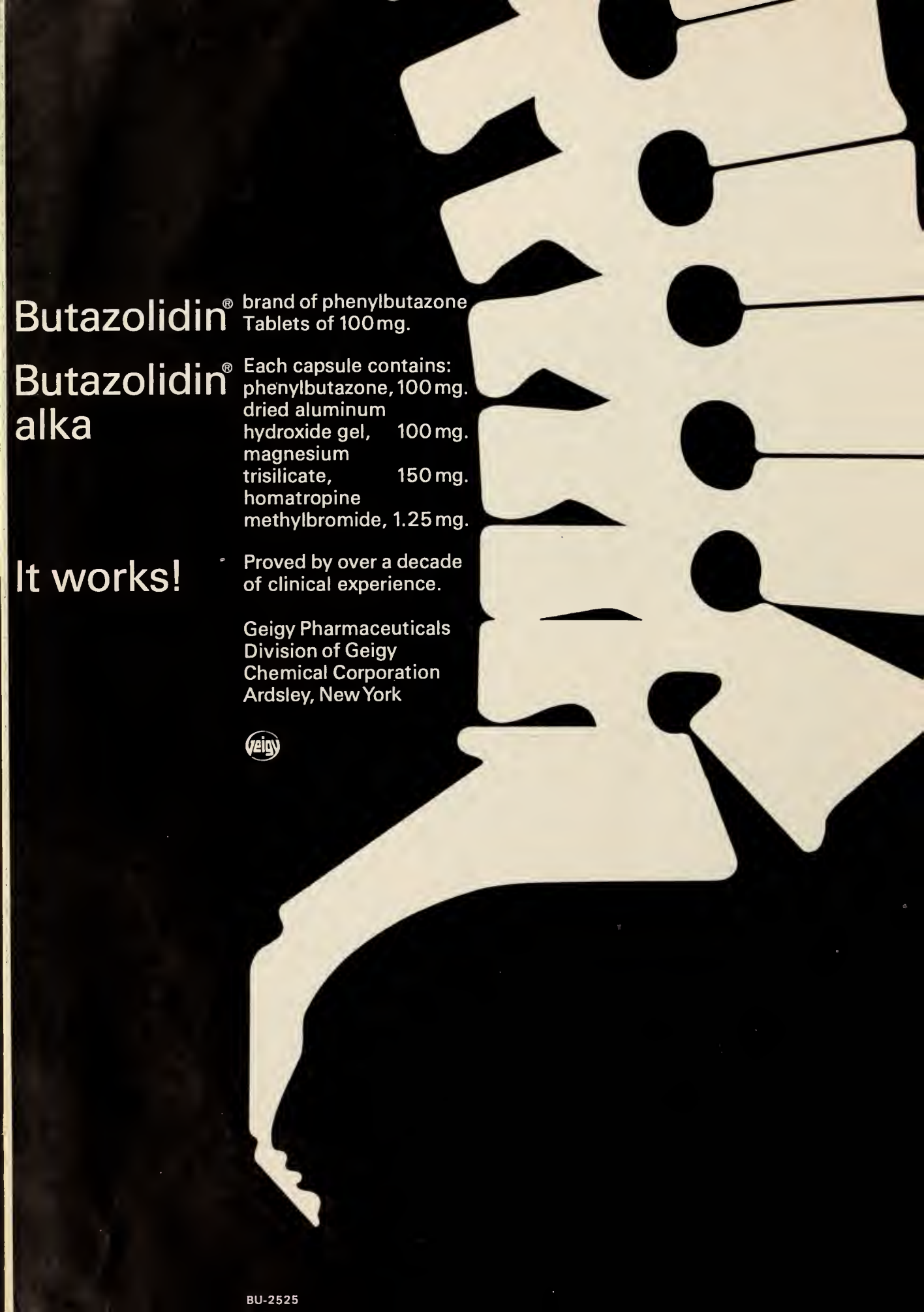
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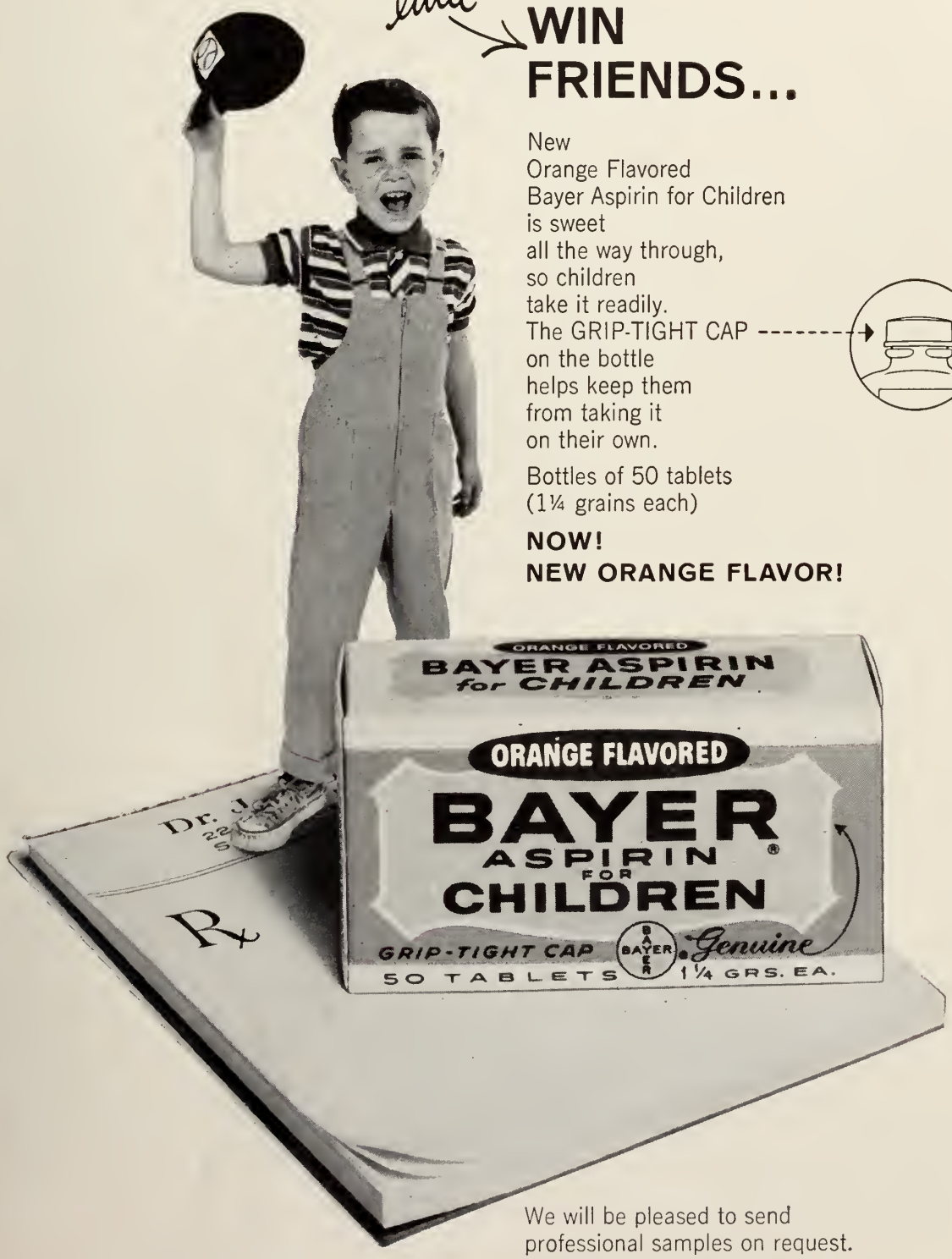


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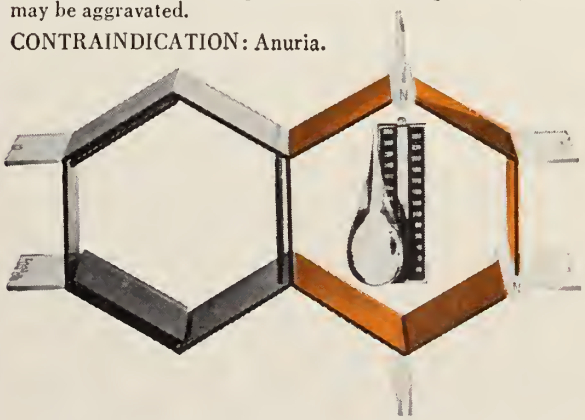
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PSYCHIATRIC ASPECTS OF MENTAL RETARDATION



James N. Sussex, M. D.

Birmingham, Alabama

When parents notice that their child is not making normal progress in its development and first suspect mental retardation, they frequently turn to their family physician or pediatrician for help. Partly they hope for reassurance that their child is normal, that he is just passing through a phase and, as a matter of fact, he may indeed be doing just that. If mental retardation is present, however, in any significant degree, then reassurance will allay their anxiety only temporarily and they will shortly be back for a reappraisal. Or, more likely, they will go to some other physician, again seeking the truth on the one hand and hoping not to hear it on the other.

All the anxieties parents have about their normal children are increased with a retarded child, and their reactions to him are even more likely to be tinged with uncertainty and inconsistency. Their natural tendency to reject the idea of his handicap may show itself in attitudes and reactions which seem to re-

*From the Department of Psychiatry, Medical College of Alabama.

veal a desire to reject the child himself. In their feeling of guilt at having such thoughts, they frequently try to make it up to the child by being over-indulgent or over-protective. Then, frustrated by failure of the child to respond to this extra attention and effort, they become irritated and impatient, again feeling guilty because they really know what they are expecting of the child is unrealistic. Thus the whole vicious circle starts over again.

From the parents' mixed feelings about his condition stem many of the special problems the mentally retarded child faces. He has just as much need for affection, acceptance, and approval as any other child, but he is far less sure than most children that he has these things. The anxieties and uncertainties of his parents communicate themselves to him and he becomes anxious and uncertain too. And the more anxious he gets, the less likely he is to do well whatever his parents try to teach him. So his own reaction contributes increasingly to the vicious circle already put in motion by his parents' two-sided feelings.

This sequence of events, to some degree almost universal in the lives of retarded children and their parents, may result in one or more of several symptom patterns about which parents usually turn to their physicians for help. The child may avoid as much as he can situations in which he is called upon to do something for fear of failure and rejection. He may withdraw as much as he can from real relationships and try to make up in fantasy what satisfactions he lacks in reality. He may develop techniques for assuring himself that his parents will continue to do things for him so, in remaining a dependent infant, he won't have to risk trying to grow up. Or, if he tries something other children his age can do and fails, he may grow frustrated and angry, perhaps have a tantrum in which he may be destructive or try to inflict physical hurt on his parents, his siblings, or even himself.

That the mentally retarded child will have difficulty in learning goes almost without saying. This is to be expected. It isn't necessary, however, for him to develop behavior disorders or neurotic disturbances if his needs are understood and met reasonably well. I want to mention several things which can help a physician recognize the source and effects of anxiety in a retarded child and his parents and which can guide his thinking in discussing management with the parents.

There is no absolutely predictable pattern of development in a retarded child but with frequent and careful observation, it is possible to make an educated guess as to when a child can be expected to walk, to attain bladder and bowel control, to understand simple language, to be able to feed himself, etc. Parents who have such guidelines are less anxious than they would be otherwise and, as a result, so is the child. Parenthetically, it may be noted that our training as physicians seldom prepares us to make this kind of prediction for a mentally retarded child and psychological testing may provide much help to the physician in making such estimates.

The mentally retarded child requires much more repetition to learn a particular thing than does the normal child. All normal children, for example, play with words in order to achieve facility in verbal communication. If the parents know that their retarded child's endless repetition of words is his attempt to master their meaning and use, they are less likely to become irritable and, therefore, less likely to cause their child to resort to a neurotic or behavioral disorder.

Mentally retarded children are capable of many abstract concepts, such as beauty, goodness, badness, approval, disapproval, honesty, and truth, although sometimes their concepts are vague and they have fewer means of expressing themselves than intellectually normal children do. Sometimes, though, a child's misconduct seems to indicate that he really doesn't understand such concepts, especially where right and wrong is concerned. One of the reasons for this is that the mentally retarded child is often easily led and suggestible. Partly this is because of his lack of critical judgment, but not infrequently it is because the person leading him is offering ac-

ceptance and approval, something the retarded child needs and wants. This need for approval and acceptance can be a force for good, assuming the leader's motives are wholesome and the activity is constructive. Obviously, however, this suggestibility of the mentally retarded child can also be a force for evil, since he may become involved in antisocial activity in order to win acceptance.

It is vitally important, then, that the mentally retarded child have models on which to pattern his behavior, and that these models should not only behave in an exemplary fashion but capitalize on the child's desire to please.

The mentally retarded child tends to think literally and concretely. He must be told or shown what is expected of him in a manner which is perfectly clear and free of ambiguity. Lack of clarity or consistency of expectation can be perplexing to any child. It may lead to total bewilderment and confusion in the retarded child who is not able to grasp many ordinarily easily understood nuances of meaning. The parents will need to watch the child carefully to ascertain what words or behavior mean to him. In this respect the retarded child can be compared to a person from a foreign country who speaks English well enough to communicate in many ways, but is unfamiliar with its idioms and colloquialisms. When conversation is on an idiomatic level, such a person might misinterpret completely the meaning of what is said to him. So may retarded children. For example, the expression "Go jump in the lake" might mean exactly that to the mentally retarded child.

The retarded child needs more protection than the normal child ordinarily does, but it should be recognized that over-protection stifles his development and prevents him from gaining experience which might lead to increased capacity for adaptation. Finding the right balance is hard enough with normal children and it is harder still with retarded children. Close supervision is required until it is clear that the child recognizes the risks involved in whatever he is doing and understands how to minimize them. To teach him how to cross a street safely is relatively easy because the dangers are obvious. To teach him to use the bus to go to his special class is more complicated. He should be taught very explicitly the dangers involved in everyday living but, hopefully, without instilling in him feelings of inadequacy or fear.

Because of her suggestibility and her need for approval and affection, the mentally retarded girl may be especially vulnerable to sexual exploitation. This is particularly true of the pretty blue-eyed blondes with phenylketonuria. These girls, then, will require especially patient and tactful explanation and instruction to prepare them to handle such a situation and yet not make them unduly frightened.

I have mentioned several times the retarded child's special need for an atmosphere of acceptance, understanding, and affection if he is to gain self-confidence and achieve a sense of personal worth and dignity. I want to emphasize that these are not synonymous with over-permissiveness. The retarded child, like any other child, needs structure and limits. Without them he becomes more anxious. But the structure and limits—the ground rules by which he is expected to play the game—must be spelled out repeatedly and explicitly.

Sometimes parents or even professional people will promise something to a retarded child in order to win his co-operation. It is even more important to the retarded child than to the normal child that the promise be kept. The normal child will frequently be able to accept an explanation why a promise cannot be fulfilled. Frequently the retarded child cannot understand the explanation and merely regards himself as betrayed—hardly a way to gain his trust and confidence, the basis on which his co-operation really rests.

Over-active behavior, scattered behavior, physical restlessness, and short attention span may be prominent symptoms, especially in children whose mental retardation is on the basis of organic brain damage. Just because

he is in action all the time the child may get into difficulty and be regarded as having a behavior disorder. In these instances, drug therapy can sometimes be helpful. The phenothiazine drugs, especially thioridazine, may be helpful if drowsiness can be avoided. Certainly it is undesirable to increase the retarded child's learning problems by dulling already reduced capacity for learning. Dexedrine derivatives or methylphenidate may also be helpful. Barbiturates frequently aggravate the symptom of hyperactivity rather than reducing it.

I might mention parenthetically that it is important to differentiate mental retardation from childhood schizophrenia, in which, without mental retardation as such, the child may be functionally retarded, and from a child with normal intelligence generally but with specific learning defects stemming from organic brain damage.

As a final note, I would like to invite your attention to the fact that we can consider the retarded child as a handicapped child or as a child with a handicap. This may seem to be a trivial difference, but it may betray a major difference in attitude in the person dealing with him. If we consider him a child with a handicap, we may find ourselves more easily oriented toward finding what his potentialities, his strong points, his healthy points are. On the other hand if we consider him as a handicapped child, implying totality of impairment, we may find ourselves relating more specifically to the lack or the defect and overlooking those very things which could help him become more effectively adjusted and happier.

WHAT IS A CLINICAL INVESTIGATOR?

In recent years, several medical schools have established centers for training clinical pharmacologists, and the Pharmaceutical Manufacturers Association and some of the leading pharmaceutical companies have made substantial grants for the support of such training programs. It is harder to define a clinical investigator, but I believe that most people would agree that a clinical investigator is a physician who has had some residency training in one of the clinical specialties, has some knowledge beyond the undergraduate curriculum of one or more of the basic sciences, and who seeks in his research to explain human disease with the help of those basic sciences. Harry F. Dowling, M. D. in J.A.M.A., 187:3 (Jan. 18) 1964.

Chromosomal Aberrations in Mental Retardation

Wayne H. Finley, Ph. D., M. D.

Birmingham, Alabama



Clinical cytogenetics is the study of the association between the patient's clinical findings and chromosomal abnormalities in his cell nuclei. In 1956[1] the chromosome number of man was established as 46, and in 1959[2] the first abnormal human chromosome complement was described. This first human chromosomal aberration was found in a mongoloid child whose cells had an extra small chromosome. This finding has been consistently present in those patients with Down's syndrome (mongolism). Chromosomal aberrations not only include extra chromosomes, but patients have now been found whose cells lack certain chromosomes and others whose cells have abnormally large or small chromosomes.

In the five years since the beginning of the field of clinical cytogenetics, a number of different chromosome abnormalities has been described. A few chromosomal syndromes have now been identified. Mental retardation is a feature in each of the established syndromes.

In order to illustrate some of the chromosomal findings it would perhaps be wise to look at the normal human chromosome complement before talking about abnormal chromosomes. Each species has a certain constant number of chromosomes as well as a constant amount of deoxyribonucleic acid (DNA) which is contained in the chromosomes and is responsible for the transmission of characteristics from one generation to the next. Contained on each set of human chromosomes is an estimated 10,000-50,000 genes. Some familial diseases, such as phenylketonuria, cystic fibrosis, and congenital adrenal hyperplasia, can be attributed to a single gene which, of course, cannot be visualized in the microscope. An extra chromosome, which conceivably could contain hundreds or even thousands of genes, can, however, be seen by the present techniques. Other diseases are undoubtedly due to several genes or so-called multifactorial inheritance. The position of

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Read at the 103rd Annual Session of the Medical Association of the State of Alabama.

any specific human gene or hereditary factor on a chromosome has not been determined although genes for color blindness, agammaglobulinemia, and hemophilia A have been located on the X chromosome. The normal human male has two sex chromosomes, one X and one Y, and 22 pairs of other chromosomes known as the autosomes. The normal human female has two X chromosomes as her sex chromosomes and the 22 pairs of autosomes. The autosomes, identical in both male and female, are arranged for study in pairs according to length, location of the centromere, and certain special characteristics such as the presence of satellites.[3] The arrangement of the chromosomes from a single cell nucleus is called a karyotype.

In the formation of the normal ovum or sperm during meiosis the chromosome number of 46 in the primordial cell is reduced to 23 in the mature germ cell. Each zygote is formed by the union of the sperm with the ovum, each of which, if normal, had 23 chromosomes originally. After the initial cell is formed, many cell divisions are necessary by the end of the first trimester before the body contains a trillion cells which have differentiated to make up the various organ systems. During this period of embryological development, it is necessary before any cell division for the DNA to replicate and thus form new chromosomes for the daughter cells. Unequal chromosome separation during meiosis or mitosis can lead to cell lines containing abnormal chromosomes.

Chromosomal aberrations such as extra chromosomes, morphological changes in chromosomes, or missing chromosomes have been estimated to occur as often as one in 100 in newborn children.[4] Generally whenever there is a variation from normal of the amount of chromatin material in the karyotype there is associated mental retardation. Since the field of clinical cytogenetics is new, then the exact significance of chromosome studies in the classification of syndromes with a feature of mental retardation is not known. At this point, though, many questions concerning the chromosomal abnormalities have been raised, and some have been answered by such studies.

The first group of established syndromes to be discussed are caused by abnormalities in the autosomes. In Down's syndrome the vast majority have an extra small chromosome, a no. 21. This occurs in one of every 600 children born and apparently is not related to race or economic conditions. This is explained on the basis of the formation of either an ovum or a sperm with an extra no. 21 chromosome which results in three no. 21 chromosomes in the karyotype (21-trisomy) on fertilization. It was soon realized that a small per cent of patients with the clinical manifestations of Down's had the normal number of 46 chromosomes.[5] This finding, though, could be explained in that two chromosomes had become attached to one another to form an abnormally large translocated chromosome A parent of such a child has been shown in several cases to be the carrier of this abnormal chromosome; whereas, in the 21-trisomy cases the parents are found to have normal chromosomes. In those cases in which the abnormal translocated chromosome can be detected, the chances for a repeat in the family is very high; whereas, in the common type the chances are not nearly so high. Some mongoloid children have now been found to be mosaic, that is, they have a mixture of different cells, some normal and some trisomy for no. 21 chromosome.[6] The level of mental development varies widely in these children, and presently there is no definite way in predicting this development. A higher mentality can be expected in those children who have part of their cells normal and only part containing the extra chromosome than can be expected in those who have an extra chromosome in all their cells.

Another autosomal syndrome is the 17-18 trisomy which was first described by Edwards et al. in 1960.[7] To date about 40 of these patients have been reported. The clinical findings are rather specific, namely, severe mental retardation as well as retardation

in growth and development, low-set malformed ears, micrognathia, congenital heart disease, and flexion deformities of the hands and feet. The extra chromosome is accounted for in a similar manner to the extra one in Down's syndrome in that either the ovum or sperm contained an extra chromosome in the 17-18 group. Life expectancy in these children is on the average about three months.

The other established autosomal syndrome is the 13-15 trisomy syndrome.[8] The clinical findings include severe mental retardation and marked retardation in growth and development, low-set malformed ears, micrognathia, cleft lip and palate, and congenital heart disease. Life expectancy is a matter of months.

While other autosomal abnormalities have been described in various clinical situations, no definite correlations can be made at this time except that an abnormally small chromosome has been found now in the majority of chronic granulocytic leukemia patients studied.

We turn now to abnormalities in the sex chromosomes. These patients make up a significant number of the patients we see in our research laboratory. Both patients with Turner's syndrome (gonadal dysgenesis) and Klinefelter's syndrome were shown to have specific chromosomal abnormalities soon after Lejeune showed the presence of an extra chromosome in a mongoloid child. The use of the sex chromatin determinations[9] in these patients has provided a means for screening. The Barr body is recognized as a distinct chromatin body closely adherent to the inner surface of the nuclear membrane in a high per cent of normal female cells, but it is not found in normal male cells. The number of sex chromatin bodies in a cell is one less than the number of X chromosomes; therefore, the normal human female (XX) is sex chromatin positive and the normal human male (XY) is negative.

In Turner's syndrome the most common karyotype finding is a 45 chromosome number with the second X chromosome missing. The sex chromatin is negative in these phenotypic females. The clinical findings are webbed neck, cubitus valgus, short stature, and streak-like gonads. Many of these individuals have subnormal intelligence, but the degree or frequency of mental retardation is markedly less than in patients with the autosomal syndromes.

Some phenotypic females have also been found to have karyotypes with three, four, and five X chromosomes instead of the normal two Xs. The clinical findings are not specific, but studies thus far show that they are apt to be in mental institutions.

In the male with Klinefelter's syndrome, the most common karyotype is one which has 47 chromosomes; the extra one is an X, thus an XXY sex chromosome pattern. The sex chromatin is positive in these cases. A significant number of these patients are mentally retarded. Phenotypic males have been found with as many as three extra X chromosomes. Several conclusions are that as the number of X chromosomes increase, the eunuchoid body proportions are more exaggerated and mental retardation becomes more severe.

At the present time karyotype interpretation is time-consuming and tedious, and such techniques must be kept on a research basis. Chromosome studies in clinical medicine are proving of value from several aspects, that is, diagnosis, prognosis, and genetic counseling. The basic questions being raised in conjunction with chromosome functions remain probably the most important aspect of clinical cytogenetics. It would appear now that research should aim at the correlation of clinical findings, chromosome studies, and biochemical investigations. DNA on the chromosomes is known now to direct the synthesis of protein and enzymes by the cell; therefore, the actual results of the defects in the gene rest in the proteins produced. By understanding these mechanisms, enzyme excesses, deficiencies, or modifications might successfully be dealt with in the not too distant future. This is particularly important in that

chromosomal aberrations are almost always associated with mental retardation.

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Ionization Of No Benefit To Respiratory Allergies

Atmospheric ionization is of no value in treating asthma, hay fever or pulmonary emphysema, according to a report in the current (June) Archives of Environmental Health, published by the American Medical Association.

A study reported by Drs. George I. Blumstein, Jay Spiegelman and Philip Kimbel, Philadelphia, contradicted reports during the past few years that an increased concentration of negative ions has a beneficial effect on some diseases while an excess of positive ions has an adverse effect on diseases. An ion is an electrically charged atom or group of atoms.

The researchers selected for study 26 patients who were "weather sensitive" in that their condition worsened during or just before changes in the weather. Twelve had hay fever, 10 had asthma, and four pulmonary emphysema.

Each patient received five consecutive daily treatments of 30-minute exposure to a concentration of negative ions, positive ions, or placebo therapy. The order of treatments was selected by a technician without the knowledge of the physician or patient. Lung function tests were performed before and after each treatment.

The study failed to show "any significant effects" when judged by subjective appraisal or objective lung function tests, the authors concluded.

"Under the condition of this experiment atmospheric ionization was of no value in the treatment of allergic diseases of the respiratory tract," they said. "Until evidence to the contrary is forthcoming, ionization should not be recommended as a therapeutic adjuvant in the treatment of these diseases."

The authors are affiliated with the Albert Einstein Medical Center.

COMPLEX CLOSED FRACTURE



H. Earle Conwell, M. D., F. A. C. S.

Conwell Orthopaedic Clinic

Birmingham, Alabama

For *many* years, I have emphasized[1-5] that the terms of simple and compound fracture are mis-nomers and not by any means always descriptive of the pathology present, especially the so-called *simple* fracture.

A *simple* fracture, so-called, can have the most complicated pathology to the surrounding tissues and many times is more complicated than the so-called compound fracture.

I insist that the simple and compound fracture terminology be changed to (a) *closed fracture* (and in many instances *complex closed fracture*) and (b) *open fracture.*

Too frequently following a traumatic condition to the body producing fracture of same without any breaking of the skin in and about the site of the fracture, it has been diagnosed as a simple fracture, but this does not describe the severity of the injuries to the fracture as well as to the surrounding tissues. Such terminology in such type accident does not outline by any means, in thousands of cases, the marked injury to the *soft tissues* as well as the marked *intramuscular hemorrhage* and does not outline the severe trauma to the *blood vessels* or the *loss of sensation* of the parts of the tissues involved, distal or proximal to the fracture. Neither does such term state the marked deformity of the limb and displacement of the fragments in many cases; but if all these exist and the skin is still not lacerated or no open wound is present, it is called a simple fracture. This is, indeed, most non-descriptive.

Therefore, a simple fracture, so-called, can have any other pathological findings than a simple condition. A so-called simple fracture

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Dr. Conwell is Associate Professor Emeritus, Orthopaedic Surgery, University of Alabama Medical College, a Life Counsellor, Medical Association of the State of Alabama, and Chief, Conwell Orthopaedic Clinic.

can indeed be much more complicated and complex than any compound fracture and it is important that we classify such fractures as *complex closed fractures.*

The emergency department of the average hospital in their out-clinic or admitting report seldom describes the severe trauma to the allied soft tissues complicating the so-called simple fracture. Therefore, realizing that the term simple fracture generally is thoroughly inadequate to describe the trauma received in such fractures, I suggest changing the term of these fractures to *complex closed fractures.*

A *complex closed fracture* is a fracture which has received severe trauma to either or all of the surrounding soft structures, i.e., skin (without open wound), muscles, blood vessels and nerves. The bony fragments frequently are displaced to a marked degree.

The complex closed fracture should be further described as to the type of bony injury. For example: *complex closed fracture* (transverse, comminuted, spiral, or oblique, as the case may be).

"Complex," as defined by "Webster's New International Dictionary," unabridged, is as follows: (1) an assemblage of related things, (2) a whole made up of complicated or interrelated parts.

I make an appeal that this fracture definition be used by the members of the medical profession. Besides expressing more adequately the pathologic findings in such type fracture, it will mean improved records for the hospitals and convey a better description of the fracture to the *insurance companies, compensation boards, legal profession,* (eliminating the too often question, *"Doctor, this was just a simple fracture, was it not?"*), all thereby being of much help to the patient, the physician, and every one concerned.

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Editorials

Guest Editorial....

Samuel Eichold, M. D.

Mobile, Alabama

For the physician, the concept of a never ending program of education is quite basic. The image of a physician is always embellished by the books which surround him, when he is viewed from near or far, in the past or present. To further serve the needs of the State of Alabama and the adjacent area, our University of Alabama has set forth a program that is known as the CONTINUING MEDICAL EDUCATION PROGRAM. This is a far reaching move. It will be felt in arithmetic progression as the years roll on. The benefits of such a program will be appreciated by the practicing physician, and greater still will be the reward for the populace at large. Dean S. Richardson Hill deserves accolades from the profession and the populace for envisioning and formulating this program.

A unique aspect of the program being developed is study of one single disease and its many ramifications. At Camp Seale Harris, during the two weeks of camping for juvenile diabetics, a ten day period is set aside for a course of study of Diabetes Mellitus. The 90 odd campers are closely followed with four fractional urinalyses and multiple microblood sugar determinations and carefully adjusted for full 24 hour chemical control. Not only is the insulin carefully prescribed at daily sessions but the administration and measurement of the insulin is critically observed for proper site of injection as well as the measurement of the single or multiple types of insulins to be injected. A full camping program provides the exercise for the juvenile diabetic. During this time, on the spot checks for hypoglycemia or its counterpart are studied and appropriately managed. No less attention is paid to the formulation of a Calculated Intake of Food for each camper. The campers are individually and collectively taught the measurement of food in household manner which makes possible the closer attainment of the desired control of the diabetic state in Camp and at home.

Those engaged in anticipating our needs for the future consider the exploding population, the extension of the life span of the individuals, and the overall desire to improve health as indicative of need for more physicians to be produced. Though these prophetic star gazers have many facts to prove this, we can hope that further dramatic developments in medical diagnostics and therapeutics will make it possible for fewer physicians to manage successfully more individuals. This may alleviate an immediate need for the expansion of the existing schools and hospitals with better utilization of that which is now avail-

able. Most important in this off-center thinking is the necessity for CONTINUING MEDICAL EDUCATION to ready the graduate and practicing physician to utilize best the available resources in the accomplishment of his dedicated purpose.

The practicing physician looks to the Medical School as the ivory tower from which new knowledge is disseminated and can be relied upon. The educational program from our Medical College of Alabama, labeled CONTINUING MEDICAL EDUCATION, is sorely needed and long awaited. Though the Hippocratic Oath is a pagan phrase, it stipulates a fundamental precept of the physician to continue to study and to pass on his knowledge to his offsprings and brothers. So the science, more than the art, is a never ending exercise in which the Medical College of Alabama is acting as the coach in a real game in which bodily contact is unavoidable!

Wide acceptance of the CONTINUING MEDICAL EDUCATIONAL program is envisioned. The participation of many members of the Medical Association of the State of Alabama in the several programs arranged for 1964 is predicted. The Study of Diabetes and Management of the Diabetic at Camp Seale Harris seems most inviting.

The Department of Continuing Education of the Medical College of Alabama and the Alabama Diabetes Association announce a 10-day course, August 13-22, 1964, in the Management of Labile Diabetes as conducted in practices at Camp Seale Harris, Scoutshire Woods, Citronelle, Alabama, in the intensive care of 90-odd campers with diabetes, aged 8 through 14. Registrants will reside at the Camp and will participate in its medical program covering all phases of diabetes care.

The diabetes program of each camper is followed daily with four fractional urinalyses and appropriate micro-blood sugars, so as to permit revision of the insulin program in order to establish or closely approximate full control during the session at Camp. Insulin writing is carried out at a 2-hour session from 10 A. M. to 12 noon daily when each camper's record is reviewed and his insulin dose ordered for the following 24 hours. As the course progresses particular campers will be assigned to registrants who will conduct under guidance the insulin program of these campers.

First-hand experience will be obtained in such phases of diabetes care as technique of insulin administration, recognition and management of insulin reactions, and adjustment of insulin dose and diet for inter-current illness and spot-check glycosuria, by registrants acting as advisors to the nursing and counsellor staff in their supervision of campers in cabins and tent units and at activities.

Each camper is placed upon prescribed and measured diet prepared and served cafeteria style under the direction of dietitians from the Alabama Dietetic Association. All campers are taught diet calculation and the actual fulfillment of the prescribed and calculated diet at each meal. Course registrants obtain a unique opportunity to become fully familiar with diets for diabetes.

Teaching sessions for the campers and discussion sessions for the registrants will be held each afternoon. Additional features will be a session on urinary tract infections by Dr. Buris Boshell, the eye in diabetes by Dr. Lubechek and the pregnant diabetic by Dr. Barnett; all on the faculty of the Medical College of Alabama.

Registration fee is $50.00 plus per diem meal cost.

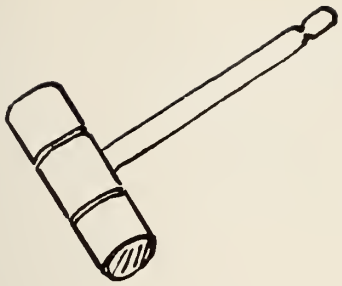
Address inquiries to Miss Jeanette Overstreet, Executive Secretary, Camp Seale Harris, 1555 Spring Hill Avenue, Mobile, Alabama.

Faculty:

Leon S. Smelo, M. D., FACP, Director
Assistant Professor of Medicine, Medical College of Alabama.

Samuel Eichold, M. D., Co-Director
Director, Camp Seale Harris

James Barrett, M. D., Physician, Camp Seale Harris, Retiring Chief Resident in Medicine, University Hospital, Birmingham, Alabama.



President's Page



The Inaugural Meeting of the Board of Trustees of the Association was held May 31, 1964 in the Board Room of the Association Building. The attendance was excellent. Two members who had asked to be excused stated they would be present at the next meeting. The attendance requirement of three unexcused absences constituting cause for replacement on the Board is the first required attendance that has been instituted in our committee structure. It hardly seems that it will be necessary to invoke this by the interest shown at this first meeting which only lasted a little over two hours. (See article on Page 17). The membership of the Board is of top-notch quality. It is a grand feeling to know that there are such upstanding men in the profession in this State who are willing to take the responsibility for such leadership as the Board offers.

Several distinguished visitors were present at this first meeting and gave invaluable help. Dr. J. Paul Jones, chairman of the Board of Censors, Dr. Luther Hill, chairman of the Subcommittee of the Board of Censors for Association Affairs, Mr. Bernard Sykes, assistant attorney general, who is attorney for the Board of Censors, and Mr. Richard M. Nelson, field representative of the American Medical Association for the Southeast Area. Mr. Nelson had been invited by the President to attend this first Board meeting several weeks previously. He felt that he could squeeze the trip in by flying from Virginia to Alabama then back to North Carolina for a Monday appointment. He described the func-

tion of the AMA Field Service Division and also made a few remarks about the King-Anderson Bill and the Appalachian Program.

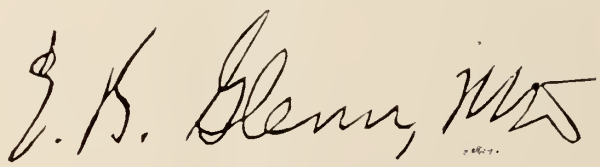
Members of the Board of Censors and the attorney, Mr. Sykes, all felt that the Board of Trustees and the Board of Censors should work closely together, and of course that is the intent in setting up the Board of Trustees. Mr. Sykes informally had previously designated the Board of Trustees as a subcommittee of the Board of Censors, and it can well be just that, getting its authority from the Board of Censors. The officers of the Association can then act with the authority of the Board of Censors. For instance the secretary-treasurer will have the necessary authority in management of the Central Office and the business of the Association since the Board of Censors places him in position to do so. By designating the duties performed by the Board of Trustees, the Board of Censors does not relinquish any of its authority, but is relieved of much detailed work that can be delegated to the Board of Trustees.

The Board of Trustees has been broken down into six subcommittees, (see article on Page 17). These subcommittees will manage the affairs of the Association. The consolidation of the efforts of these subcommittees will constitute the report of the Board of Trustees to the Board of Censors twice a year in October and February.

At present there appears no need for a change in the Constitution. There are several changes that are to be recommended in the Ordinances at the next annual meeting. But these have mainly to do with the number and size of the present committees.

The Committees of the Association are being asked to meet at least twice a year. Meetings were held as follows: June 28, 10:00 A. M., Committee on Medical Education and Hospitals; July 1, 2:00 P. M., Committee on Aging and the Indigent. Other meetings are scheduled as follows: July 19, 10:00 A. M., Committee on Public Relations and Committee on Legislation; July 26, 10:00 A. M., Committee on Allied Medical Services, and Maternal and Child Health; July 26, 2:00 P. M., Committee on Rural Health of Alabama and Committee on Constitution and By-Laws, (See article on Page 17). Each chairman is asked to dictate the report of his Committee on the dictating machine before he leaves the building. In this way the words of the chairman will be accurately recorded.

The efficiency of the Organization is increasing and the representation of the membership is broadened by bringing the Board of Trustees into being.



E. B. Glenn, M. D.

around the state



Alabama High School Girl Wins

Trip To AMA Annual Convention

An 18-year-old Alabama girl, Miss Gail Maxine Houston, a senior at Sylacauga High School and a resident of Goodwater, was an honored guest at the AMA 113th Annual Convention in San Francisco, June 21-25, as a result of her winning one of the AMA's two top awards at the 15th National Science Fair-International in Baltimore, Md., May 6-9. She is pictured here with Dr. Edward R. Annis, Miami, Fla., past president AMA, and her co-winner, Gregory S. Lumbra of Bloomington, Ind.

Her exhibit, selected by a panel of AMA judges from a field of over 400 entries from the U. S., South America, Asia, and Europe, was on "Rous Sarcoma—Preparation of Heat-Killed Vaccine and Antiserum." Doctor Annis presented her with a citation and the invitation to the Convention at the Health Awards Banquet, co-hosted by the AMA, the American Dental Association, the American Pharmaceutical Association, and the American Veterinary Medical Association.

The AMA has been participating in the National Science Fair, administered by Science Service, for the past nine years as part of its continuing program to interest talented students in the study of medicine.

Medical Progress Assembly

Alabama physicians are invited to attend an unusual "Medical Weekend in Birmingham" September 12-15, 1964, which will feature lectures, seminars and panel discussions by 56 physicians covering a broad range of subjects.

All programs will be at Birmingham's elegant new Parliament House Motor Hotel. Lavish social functions will be interspersed with the scientific meetings. A total of 22 hours of Category I credit will be allowed by the American Academy of General Practice for the programs.

The weekend opens September 12 with a seminar on "Newer Concepts of Female Reproductive Physiology," featuring addresses by nine national leaders in obstetrical-gynecological education, research, and practice. The visiting physicians will join Birmingham physicians for panel discussions on "Control of Ovulation-Contraception," "Hormonal Therapy of Endocrine Dysfunctions," and "Treatment of Infertility."

This will be followed September 13 by the Seventh Annual Medical Progress Assembly of the Birmingham Academy of Medicine which opens that evening with a social hour and dinner at which famed University of Alabama football Coach Paul (Bear) Bryant will be kickoff speaker.

On Monday and Tuesday outstanding medical lecturers will discuss such subjects as headaches, strokes, malabsorptive syndromes, the acutely injured patient, pediatric surgery, the acute abdomen, monitors in anesthetic practice, gastrointestinal bleeding, snakebite, shock, otosclerosis, and many other topics.

Special entertainment features for physicians and wives will include social hours, luncheons, dinners, dances, tours, and a fashion show for the ladies. Door prizes will be awarded and refreshments will be served during intermissions.

Complete programs will be sent upon request to Ob-Gyn Seminar or Medical Progress Assemby, c/o JCMS, 901 South 18th Street, Birmingham, Alabama 35205.

PROGRAM

DIXIE POSTGRADUATE ASSEMBLY

September 24, 25, 26, 1964

DAUPHIN ISLAND (Mobile), ALABAMA

Thursday Afternoon, 24 September 1964

Snakebite
By Robert P. Knowles, D. V. M., Research Instructor, Departments of Biochemistry and Experimental Surgery, University of Miami School of Medicine, Miami, Florida.

The After Care of Acute Myocardial Infarction
By C. Thorpe Ray, M. D., Professor and Chairman, Department of Medicine, University of Missouri Medical Center.

Gout
By William P. Beetham, Jr., M. D., Assistant Professor of Medicine, Division of Rheumatology, Medical College of Alabama.

Emphysema
By Morton F. Ziskin, M. D., Professor of Medicine, Tulane University School of Medicine.

Friday Afternoon, 25 September 1964

A New Look at the Menopause
By William E. Barfield, M. D., Associate Clinical Professor, Obstetrics and Gynecology, Medical College of Georgia.

The Etiology and Management of Ureteral Stones
By Rafe Banks, Jr., M. D., Instructor of Urology, Emory University Medical School.

The Newer Progestational Agents
By Buford Word, M. D., Assistant Professor of Obstetrics and Gynecology, University of Alabama.

Panel Discussion on Sterility
By Drs. Barfield, Banks and Word.

Saturday Morning, 26 September 1964

Regional and Local Anesthesia
By Leonard W. Fabian, M. D., Professor and Chairman, Department of Anesthesiology, University of Mississippi School of Medicine.

What About Proctoscopy?
By Newton D. Smith, M. D., Private Practice, Ft. Worth, Texas.

A Discussion—Immune Procedures
By James L. Goddard, M. D., Assistant Surgeon General, Chief, Communicable Disease Center, Atlanta, Georgia.

Sports Injuries and Physical Fitness
By Thomas O. Schindler, M. D., Orthopedic Consultant, Houston Oilers Professional Football Team.

ORGANIZATION SECTION

BOARD OF TRUSTEES HOLDS INAUGURAL MEETING

The newly appointed Board of Trustees of the Medical Association of the State of Alabama held its first meeting on May 31, at the Association Building in Montgomery. The attendance was excellent.

Membership on the Board includes: Dr. E. B. Glenn, President, who serves as chairman; Dr. James G. Donald, President-Elect; Dr. William L. Smith, Secretary-Treasurer; Drs. John M. Chenault, M. Vaun Adams, and E. Bryce Robinson, Jr., AMA Delegates; Drs. H. E. Askin, H. J. Campbell, E. L. Strandell, and G. H. Stokes, Vice-Presidents; Dr. J. Paul Jones, Chairman of the Board of Censors or his representative; and one member each from the Congressional Districts which are appointed by the President, and include Drs. John Day Peake, William A. Daniel, Jr., Luther Cooper, Arthur F. Toole, Ellis Porch, Thomas B. Norton, Henry Hodo, Jr., R. M. Miller, and S. Buford Word.

The first meeting was a productive one. The committee considered very carefully the duties that were assigned to them by the Board of Censors at its meeting on May 20, 1964. The duties of the Board of Trustees as approved by the Board of Censors are as follows:

I. To the Board of Trustees shall be referred without discussion:

All motions, resolutions, or inquiries, of whatever nature, affecting the organization, policy, or welfare of the Association, or of any one or more of the county societies in affiliation therewith;

All proposed amendments to the constitution, ordinances, or by-laws of the Association with exception of Resolution I which has already been referred to the Constitution and By-Laws Committee;

The message of the president delivered at the annual session and any recommendations he may submit to the Association at any called session;

All reports and recommendations of the vice-presidents submitted to the Association at any annual, or called session;

All reports and recommendations of

the secretary, the treasurer, and the publishing committee submitted to the Association at any regular or called session;

All questions involving the principles of ethics to which the Association has declared its allegiances;

The Board of Trustees of this Association shall receive regular progress reports and recommendations from the standing and special committees of this Association;

It shall be the duty of the Board of Trustees to recommend to the Board of Censors what action it deems necessary.

II. The Board of Trustees will assume duties of the Finance Committee;

The Board of Trustees shall examine monthly and audit the accounts of the secretary and treasurer and report same to the Association quarterly through the Board of Censors;

The Board of Trustees shall estimate the probable financial needs of the Association for the ensuing year and shall prepare an annual budget for the ordinary expenses of the Association and submit it to the Association for approval at the annual meeting;

The Board of Trustees shall have full responsibility for the financing and programming of the annual meeting of the Association.

III. The Board of Trustees shall appoint an editor of the *Journal* from its own membership or from the Association at large.

IV. The Board of Trustees may employ an executive secretary for the Association who need not be a physician nor a member of the Association. By resolution of the Board, the Board of Trustees may assign to such employed officer so much of the duties of the secretary of the Association, the treasurer of the Association, the secretary of the Board of Trustees, and the secretaryship of the several committees as the Board may deem advisable and beneficial to the Association and which are not in conflict with the Constitution and By-Laws;

At the discretion of the Board of Trustees such executive secretary shall be reappointed and the terms and length of his contract determined at that time;

The Board of Trustees shall furnish to the executive secretary those items to be included in the Handbook for Counsellors and Delegates prior to the first Monday in February.

V. It shall be the duty of the Board of Trustees to provide necessary office space, equipment, and personnel to conduct the administrative affairs of the Association in a manner that will reflect credit to the Medical Association of the State of Alabama.

VI. The Executive Council of the Board of Trustees shall consist of:

1. The President of the Association, who will be Chairman,
2. Immediate Past-President of the Association,
3. The President-Elect of the Association,
4. The Chairman of the Board of Censors,
5. The Secretary-Treasurer of the Association;

The Board of Trustees shall authorize the Executive Council to act for it on minor matters and to act provisionally in emergencies.

VII. Any member of the Board of Trustees who misses three meetings within one year without being excused, shall be replaced by another who will be appointed by the Executive Council. The secretary of the Board of Trustees shall keep attendance records and re-

port any member who has been absent three times without excuse.

VIII. The Board of Trustees shall present to the Board of Censors during the first two weeks of October a progress report upon all the affairs of the Association. Further, the Board of Trustees shall present to the Board of Censors an annual report of the affairs of the Association in April and prior to the opening of the Annual Session.

IX. The duties and responsibilities assigned to the Board of Trustees will be effective until the next regular meeting of the House of Delegates and Counsellors in April 1965.

X. All proposed acts and recommendations of the Board of Trustees shall be presented to the Board of Censors for approval before taking effect.

The chairman assigned six subcommittees which consisted of: (1) Annual Meeting, composed of Drs. Campbell, Peake, and Daniel; (2) Administration (Central Office) Drs. Smith, Daniel, Hodo, and Miller; (3) Legislation, Drs. Strandell, Cooper, Chenault, Adams, and Miller; (4) Finance, Drs. Robinson, Toole, Smith, and Daniel, with the Board of Censors Subcommittee as ex officio members; (5) Committee Reports, Drs. Donald, Porch, Norton, Stokes, and Askin; (6) Rules for the Board of Trustees, Drs. Word, Glenn, and Smith.

It is the feeling of the Board that the majority of the work can be done in subcommittees, and it has been agreed that subcommittees will meet prior to each Board meeting to discuss any matters relative to that particular subcommittee. Reports will then be made to the full Board for approval.

The Board of Trustees has asked all Committees of the Association to meet at least twice annually. Scheduled on July 19 are Committee on Public Relations and Committee on Legislation and on July 26, Allied Medical Services, Maternal and Child Health, Rural Health Council of Alabama, and Constitution and By-Laws.

Other committees met in June and the first part of July.

The arrangement of establishing the Board of Trustees will tremendously lessen the work of the Board of Censors, and it is believed that this can be accomplished without a constitutional change but merely changes in the Ordinances of the Association.

VISIT YOUR ASSOCIATION BUILDING

19 South Jackson Street

MONTGOMERY, ALABAMA

Alabama Department of Public Health

THE IMMUNIZATION PROJECT

The Alabama Immunization Project is designed to protect people against certain diseases by promoting vaccinations throughout the state.

The immunization program is a co-operative effort of the Alabama Department of Public Health, county health departments, and county medical associations. These groups are centering their activities around obtaining higher levels of protection against diphtheria, pertussis, tetanus, polio, and smallpox.

Dr. Ira L. Myers, state health officer, outlines the "Immunity for Your Community" program this way:

Approach—Prevention of disease by immunization, with emphasis on children under five.

Scope—County-to-county by invitation of the medical society and county health department until the program covers every area of Alabama.

Method—(1.) A house-to-house systematic sampling survey to determine immunization levels. (2.) A follow-up campaign to eliminate or reduce unimmunized and partially immunized levels. (3.) A continuous program to maintain high levels of immunization.

Supervision—The county medical society and county health officer, in co-operation with the Alabama Department of Public Health.

Staff—A project co-ordinator, field agents, statisticians, stenographers, a health educator, and an information specialist.

Four counties—Perry, Houston, Franklin, and Chambers—have been surveyed and followed-up since the program began early this year. Project personnel are completing the first phases of the program in the Escambia, Monroe, and Conecuh area, and the field agents are preparing to move into Pike, Covington, Coffee, and Geneva counties.

The plan has worked well. In the first four counties covered, each county health department has reported "significant" increases in immunizations given. For example, more than 1,100 immunizations against DPT, polio, and smallpox were given at the Uniontown (Perry County) unit during two clinic sessions following the survey. (This figure is more than ten times the "normal" clinic load.) In Houston County the Madrid clinic reported 80 immunizations given compared to the usual handful.

While immunizations levels were lowest among indigents and the lower socio-economic group, several private physicians in these areas have also noted a higher demand for their immunization services.

State health officials credit much of this success to private physicians, medical societies, and county health departments. They cite the prominent roles played by Dr. Ben R. Byrd and Dr. Samuel W. Windham in the first Wiregrass campaign. Dr. Byrd, president of the Houston County Medical Society, vigorously supported the program. Dr. Windham, chairman of the Houston County Board of Censors, made a promotional television appearance with Dr. Sam T. Simpson, county health officer.

In Franklin County medical doctors co-operated with County Health Officer, Dr. R. E. Harper, in the first North Alabama immunization survey. Dr. J. R. Long, then Perry County Health Officer, praised local

physicians for their "outstanding, wholehearted co-operation." Co-operation from private physicians in Chambers County was also reported by Dr. T. N. Page, county health officer.

These systematic surveys uncovered marked immunization deficiencies, particularly among rural white and Negro populations. One county indicated only one in ten of a specific age group protected against tetanus. In another county, only eight per cent of children under five had smallpox vaccinations. The survey findings in every area indicated many children with primary DPT protection were neglecting their booster vaccinations.

With excellent, effective immunizations available, project personnel wonder why people still suffer and die from certain communicable diseases. A prominent Alabama physician answered this way, "We have safe, effective vaccines, and we know just when to use the injections. We even have a painless, sugar-cubed polio vaccine—but we haven't stopped DPT and polio or the threat of smallpox. Telling the people what's on the medical menu and to 'come and get it' isn't enough. Something must be done to arouse susceptible people out of a slumbering apathy."

Immunization project personnel are trying to do just that—find and wake up the unprotected people and get them moving toward their doctor's office or a local county health department. These public health workers are scanning maps, computing statistics, preparing promotional publicity, knocking on a multitude of doors and querying parents. Everything from the planning stage to the grass roots effort moves toward one goal—protecting the unprotected.

Facing three traditional enemies of progress—ignorance, apathy, and poverty—public health workers are promoting disease protection by immunizations.

Physicians and the Alabama Department of Public Health are alerting Alabamians—asking people "not to wait until too late to vaccinate."

BUREAU OF LABORATORIES

Thomas S. Hosty, Ph.D., Director

April 1964

Examinations for intestinal parasites	1,416
Typhoid cultures (feces, urine and other)	219
Brucella cultures	1
Examinations for malaria	3
Examinations for gonococci	1,750
Serologic tests for syphilis (blood and spinal fluid)	23,325
Darkfield examinations	4
Examinations for diphtheria bacilli and Vincent's	20
Complement fixation tests	40
Examinations for Negri bodies (smears and animal inoculations)	248
Water examinations	2,307
Milk and dairy products examinations	3,822
Examinations for tubercle bacilli	3,843
Miscellaneous examinations	4,221
Total	41,219

BUREAU OF PREVENTABLE DISEASES

W. H. Y. Smith, M. D., Director

CURRENT MORBIDITY STATISTICS

1964

	March	April	*E. E. April
Tuberculosis	90	95	138
Syphilis	125	117	142
Gonorrhea	280	294	311
Chancroid	0	0	4
Typhoid fever	0	0	1
Undulant fever	1	1	0
Amebic dysentery	5	3	6
Scarlet fever & strep. throat	89	38	151
Diphtheria	2	0	2
Whooping cough	15	11	33
Meningitis	7	7	6
Tularemia	0	0	1
Tetanus	0	0	1
Poliomyelitis	0	0	0
Encephalitis	0	0	1
Smallpox	0	0	0
Measles	225	497	502
Chickenpox	106	143	252
Mumps	126	613	192
Infectious hepatitis	44	29	37
Typhus fever	0	0	0
Malaria	0	0	0
Cancer	413	884	559
Pellagra	1	2	0
Rheumatic fever	28	13	16
Rheumatic heart	24	31	25
Influenza	135	167	935
Pneumonia	285	229	263
Rabies—Human cases	0	0	0
Pos. animal heads	1	6	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

BUREAU OF LABORATORIES

Thomas S. Hosty, Ph.D., Director

May, 1964

Examinations for intestinal parasites	1,235
Typhoid cultures (feces, urine and other)	221
Brucella cultures	0
Examinations for malaria	7
Examinations for gonococci	1,793
Serologic tests for syphilis (blood and spinal fluid)	24,028
Darkfield examinations	3
Agglutination tests	4
Examinations for diphtheria bacilli and Vincent's	12
Complement fixation tests	30
Examinations for Negri bodies (smears and animal inoculations)	277
Water examinations	2,512
Milk and dairy products examinations	4,057
Examinations for tubercle bacilli	3,753
Miscellaneous examinations	3,925
Total	41,857

BUREAU OF PREVENTABLE DISEASES

W. H. Y. Smith, M. D., Director

Current Morbidity Statistics

1964

	April	May	*E. E. May
Tuberculosis	95	177	173
Syphilis	117	135	129
Gonorrhea	294	361	327
Chancroid	0	6	1
Typhoid fever	0	1	2
Undulant fever	1	0	0
Amebic dysentery	3	5	2
Scarlet fever & strep. throat	38	42	77
Diphtheria	0	0	1
Whooping cough	11	62	23
Meningitis	7	9	8
Tularemia	0	0	0
Tetanus	0	1	3
Poliomyelitis	0	2	1
Encephalitis	0	0	1
Smallpox	0	0	0
Measles	497	15,229	478
Chickenpox	143	729	171
Mumps	613	590	30
Infectious hepatitis	29	44	46
Typhus fever	0	0	0
Malaria	0	0	0
Cancer	884	928	620
Pellagra	2	5	0
Rheumatic fever	13	34	10
Rheumatic heart	31	26	31
Influenza	167	90	144
Pneumonia	229	297	211
Rabies—Human cases	0	0	0
Pos. animal heads	6	3	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

BUREAU OF VITAL STATISTICS

Ralph W. Roberts, M. S., Director

PROVISIONAL BIRTH AND DEATH STATISTICS FOR FEBRUARY AND COMPARATIVE DATA

Live Births / Deaths / Causes of Death	Number Registered During February 1964			Rates* (Annual Basis)		
	Total	White	Non-White	1964	1963	1962
Live Births	6,110	3,858	2,252	22.6	22.4	24.0
Deaths	2,539	1,619	920	9.4	11.0	9.6
Fetal Deaths	92	42	50	14.8	17.5	15.6
Infant Deaths						
under one month	121	52	69	19.8	20.4	16.5
under one year	211	80	131	34.5	40.3	29.0
Maternal Deaths	6	1	5	9.7	11.9	9.6
Causes of Death						
Tuberculosis, 001-019	20	10	10	7.4	9.3	5.8
Syphilis, 020-029	4	4		1.5	1.9	1.2
Dysentery, 045-048						0.4
Diphtheria, 055						
Whooping cough, 056						
Meningococcal infections, 057	2	2		0.7	0.4	
Poliomyelitis, 080, 081	1	1		0.4		
Measles, 085					0.4	0.8
Malignant neoplasms, 140-205	275	198	77	101.9	128.0	120.4
Diabetes mellitus, 206	36	26	10	13.3	17.8	17.2
Pellagra, 281						
Vascular lesions of central nervous system, 330-334	368	211	157	136.4	150.0	136.8
Rheumatic fever, 400-402	1		1	0.4	0.8	
Diseases of the heart, 410-443	890	661	229	329.9	359.9	326.2
Hypertension with heart disease, 440-443	131	61	70	48.6	54.9	60.8
Diseases of the arteries, 450-456	56	29	27	20.8	22.4	23.0
Influenza, 480-483	8	6	2	3.0	20.9	13.2
Pneumonia, all forms, 490-493	95	51	44	35.2	57.2	28.8
Bronchitis, 500-502	6	6		2.2	3.9	1.6
Appendicitis, 550-553	4	2	2	1.5	0.8	1.2
Intestinal obstruction and hernia, 560, 561, 570	13	9	4	4.8	7.3	5.5
Gastro-enteritis and colitis, under 2, 571.0, 764	17	3	14	6.3	5.0	5.5
Cirrhosis of liver, 581	13	7	6	4.8	6.6	7.4
Diseases of pregnancy and childbirth, 640-689	6	1	5	9.7	11.9	9.6
Congenital malformations, 750-759	31	24	7	5.1	5.9	4.5
Immaturity at birth, 774-776	31	11	20	5.1	5.0	5.4
Accidents, total, 800-962	141	86	55	52.3	59.9	53.0
Motor vehicle accidents, 810-835, 960	49	42	7	18.2	20.5	24.6
All other defined causes	359	215	144	133.1	150.4	140.7
Ill-defined and unknown causes, 780-793, 795	162	56	106	60.0	73.5	43.3

*Rates—Birth and death—per 1,000 population
Infant deaths—per 1,000 live births
Fetal deaths—per 1,000 deliveries
Maternal deaths—per 10,000 deliveries
Deaths from specified causes—per 100,000 population

BUREAU OF VITAL STATISTICS

Ralph W. Roberts, M. S., Director

PROVISIONAL BIRTH AND DEATH STATISTICS AND COMPARATIVE DATA, MARCH 1964

Live Births / Deaths / Causes of Death	Number Registered During March 1964			Rates* (Annual Basis)		
	Total	White	Non-White	1964	1963	1962
Live Births	5,934	3,779	2,155	20.6	22.1	23.7
Deaths	2,781	1,810	971	9.6	11.6	9.0
Fetal Deaths	126	50	76	20.8	19.1	16.3
Infant Deaths—						
under one month	121	71	50	20.4	17.7	19.8
under one year	202	99	103	34.0	30.0	32.3
Maternal Deaths	3	1	2	5.0	10.9	5.9
Causes of Death						
Tuberculosis, 001-019	25	12	13	8.7	11.2	7.8
Syphilis, 020-029	5		5	1.7	1.0	1.8
Dysentery, 045-048						0.4
Diphtheria, 055						
Whooping cough, 056						0.4
Meningococcal infections, 057	2	1	1	0.7	0.3	0.7
Poliomyelitis, 080, 081					0.3	
Measles, 085	2	2		0.7		0.7
Malignant neoplasms, 140-205	368	265	103	127.6	124.0	107.6
Diabetes mellitus, 260	37	21	16	12.8	17.5	13.0
Pellagra, 281					0.7	
Vascular lesions of central nervous system, 330-334	394	248	146	136.6	161.0	121.3
Rheumatic fever, 400-402	1		1	0.3	1.0	0.7
Diseases of the heart, 410-443	898	646	252	311.4	351.3	320.2
Hypertension with heart diseasc, 440-443	126	56	70	43.7	51.0	48.7
Diseases of the arteries, 450-456	57	40	17	19.8	22.3	23.6
Influenza, 480-483	8	3	5	2.8	48.9	6.3
Pneumonia, all forms, 490-493	113	66	47	39.2	74.7	32.4
Bronchitis, 500-502	6	6		2.1	3.5	3.2
Appendicitis, 550-553	4	4		1.4	0.7	0.7
Intestinal obstruction and hernia, 560, 561, 570	15	12	3	5.2	2.8	4.6
Gastro-enteritis and colitis, under 2, 571, 0, 764	8	2	6	2.8	1.7	2.1
Cirrhosis of liver, 581	21	17	4	7.3	5.6	3.2
Diseases of pregnancy and childbirth, 640-689	3	1	2	5.0	10.9	5.9
Congenital malformations, 750-759	26	16	10	4.4	4.1	4.6
Immaturity at birth, 774-776	34	22	12	5.7	5.5	4.3
Accidents, total, 800-962	176	134	42	61.0	70.9	57.1
Motor vehicle accidents, 810-835, 960	79	64	15	27.4	25.5	24.3
All other defined causes	394	227	167	136.6	161.7	130.1
Ill-defined and unknown causes, 780-793, 795	184	65	119	63.8	80.0	37.4

*Rates: Birth and death—per 1,000 population
Infant deaths—per 1,000 live births
Fetal deaths—per 1,000 deliveries
Maternal deaths—per 10,000 deliveries
Deaths from specified causes—per 100,000 population

BUREAU OF VITAL STATISTICS

Ralph W. Roberts, M. S., Director

PROVISIONAL BIRTH AND DEATH STATISTICS AND COMPARATIVE DATA, APRIL 1964

Live Births / Deaths / Causes of Death	Number Registered During April 1964			Rates* (Annual Basis)		
	Total	White	Non-White	1964	1963	1962
Live Births	5,626	3,641	1,985	20.2	19.5	21.6
Deaths	2,530	1,646	884	9.1	9.3	9.6
Fetal Deaths	95	45	50	16.6	21.7	19.7
Infant Deaths—						
under one month	110	56	54	19.6	23.7	19.4
under one year	171	81	90	30.4	32.8	30.4
Maternal Deaths	8	2	6	14.0	5.4	8.3
Causes of Death						
Tuberculosis, 001-019	19	11	8	6.8	9.4	10.6
Syphilis, 020-029	4	1	3	1.4	1.1	1.1
Dysentery, 045-048						0.4
Diphtheria, 055						
Whooping cough, 056					0.4	
Meningococcal infections, 057	3	2	1	1.1	0.4	0.7
Poliomyelitis, 080, 081						
Measles, 085	1	1		0.4		1.5
Malignant neoplasms, 140-205	344	254	90	123.2	103.9	113.3
Diabetes mellitus, 260	43	24	19	15.4	13.7	15.3
Pellagra, 281					0.4	0.4
Vascular lesions of central nervous system, 330-334	333	213	120	119.3	128.1	128.6
Rheumatic fever, 400-402	3	1	2	1.1	0.7	
Diseases of the Heart, 410-443	862	619	243	308.8	323.3	338.2
Hypertension with heart disease, 440-443	131	53	78	46.9	47.6	52.5
Diseases of the arteries, 450-456	57	36	21	20.4	20.2	23.7
Influenza, 480-483	1		1	0.4	14.4	5.1
Pneumonia, all forms, 490-493	87	47	40	31.2	31.4	32.1
Bronchitis, 500-502	3	2	1	1.1	1.8	2.2
Appendicitis, 550-553	5	3	2	1.8	1.4	1.1
Intestinal obstruction and hernia, 560, 561, 570	8	3	5	2.9	4.0	5.1
Gastro-enteritis and colitis, under 2, 571, 0, 764	4	2	2	1.4	1.8	2.6
Cirrhosis of liver, 581	16	14	2	5.7	4.7	6.2
Diseases of pregnancy and childbirth, 640-689	8	2	6	14.0	5.4	8.3
Congenital malformations, 750-759	28	22	6	5.0	5.0	5.1
Immaturity at birth, 774-776	37	15	22	6.6	7.0	5.1
Accidents, total, 800-962	163	105	58	58.4	64.2	66.7
Motor vehicle accidents, 810-835, 960	64	50	14	22.9	26.3	30.6
All other defined causes	351	213	138	125.8	129.9	139.9
Ill-defined and unknown causes, 780-793, 795	150	56	94	53.7	52.3	41.2

*Rates: Birth and death—per 1,000 population
Infant deaths—per 1,000 live births
Fetal deaths—per 1,000 deliveries
Maternal deaths—per 10,000 deliveries
Deaths from specified causes—per 100,000 population

The Woman's Auxiliary



Dear Doctors:

Like a number of you, Lowell and I are planning and getting ready for our trip to San Francisco next week. It is a little more complicated than past trips. Instead of calling Eastern to figure out the schedule and make the reservations, we are going in the Twin Bonanza and are figuring out flight plans, converting nautical miles into statute miles, figuring elevations, and wondering if there will be head winds, tail winds, or cross winds. It will make a difference where we stop for coffee and gasoline and where we'll sleep Friday and Saturday nights. We can't get to San Francisco before Sunday because that's when the hotel reservations start.

San Francisco is going to be fun. There will be good food, no cuisine, and old friends to see. The Auxiliary meetings will be wonderful, just like an old-fashioned Baptist Revival, and we will all come home inspired and ready to make big plans for next year.

Lowell won't admit it but I think he's looking forward to the harem he will acquire when he gets out there. There are always some widows, mamas who came to look after Auxiliary business while Papa stayed home to deliver that cherished O. B. Lowell wrote a column last fall about the widows on the state level and I want to quote from it.

"Our traveling together or with the entire family has always been very simple—to me. Frances packs everything, unpacks everything, keeps track of everything, and there is actually not too much housework for me to do. When I travel by myself, Frances packs my clothes and I usually live out of a suitcase until I am ready to head for home. At that time I usually gather everything in sight and throw it all into the suitcase so that Frances can do the unpacking and sorting when I get home. I kinda figured that with the traveling that she will now have to do by herself, she will get along fine because she has been so well trained.

"Last week she had to go to Birmingham and spend several days down there at a board meeting. As her husband, I was invited to attend a dinner meeting on Thursday night, so Thursday evening I leisurely drove down and went to the motel where I had made reservations for her to stay. She and her good friend, Belle Chenault from Decatur, were in our room going over various items of business. Upon my arrival she said, 'Good. I'm glad you got here.' Then she turned to Belle and said, 'Belle, you won't have to stay now because Lowell can zip up my dress.' So Belle went to her room and I zipped up Frances' dress so that she could go to the dinner. It made me feel real important and needed.

"I didn't realize that for years I had been zipping and unzipping, and actually my presence had some value when Frances gets ready to dress or undress. Now I am wondering how women all over the world manage to travel by themselves with nobody to do the zipping or unzipping. Perhaps this is the duty of the bell-boys, or hotel managers, or lady friends, or passers-by. Don't see how a woman can possibly travel without her husband."

I'll be so inspired with Auxiliary projects next month that I may not be able to tell you about the Oriental Fashion Show we are going to see Sunday afternoon.

Sincerely,

Frances Clemmons
(Mrs. Lowell H.)

in virtually all diarrheas...prompt symptomatic control

LOMOTIL®

TABLETS / LIQUID—Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate . . . . . 0.025 mg.



Lomotil controls the basic physiologic dysfunction in diarrhea—excessive propulsive motility. Pharmacologic evidence indicates that it does so by directly inhibiting propulsive movements of the intestines. This direct, well-localized activity controls diarrheas of widely varied origin and does so promptly, conveniently and economically.

The relatively few conditions in which Lomotil has given less than satisfactory control have been, for the most part, those such as severe ulcerative colitis in which too little anatomic or functional capacity of the intestines remains for the motility-lowering action of Lomotil to have effect.

It should be noted, however, that Lomotil has proved highly useful in mild to moderate ulcerative colitis and in several other refractory forms of diarrhea.

The recommended initial adult dosage is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is controlled. Maintenance dosage may be as low as two tablets daily. *Children's* daily dosage (in divided doses) varies from 3 mg. for a child of 3 to 6 months to 10 mg. for one 8 to 12 years of age. Lomotil is an exempt narcotic; its abuse liability is low and comparable to that of codeine. Recommended dosages should not be exceeded. Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia. Lomotil should be used with caution in patients with inpaired liver function and in patients taking addicting drugs or barbiturates. Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Research in the Service of Medicine SEARLE



Outwardly calm...but what goes on inside?

Appearances on the outside do not necessarily suggest what goes on inside. This is particularly true of the ulcer patient, who may appear jolly and unruffled to his neighbors, but presents to you the classic symptoms: organic and functional disorders of the G.I. tract, associated with anxiety and tension.

Consider, when you see him next, the value of PATHILON® SEQUELS® with Phenobarbital, which provides sustained anticholinergic protection from spasm and pain in the target areas, as well as sustained phenobarbital action against triggering anxiety. The controlled release of the active ingredients in the SEQUELS® formulation means protective medication day and night.

Effective in peptic ulcer, intestinal colic, ileitis, esophageal spasm, spastic colon, alcohol-induced G.I. upsets, gastric hypermotility and anxiety neurosis with G.I. symptoms. Should be used as adjunct to other measures.

Side Effects (due to tridihexethyl chloride): dry mouth, blurring of vision, constipation.

Contraindications: urinary bladder neck obstruction; glaucoma; obstructive congenital anomalies of the gastrointestinal tract; pyloric obstruction; congenital megacolon; and stenosing gastric or duodenal ulcer with significant gastric retention.

Also available, without phenobarbital, as PATHILON® Tridihexethyl chloride SEQUELS® 75 mg.

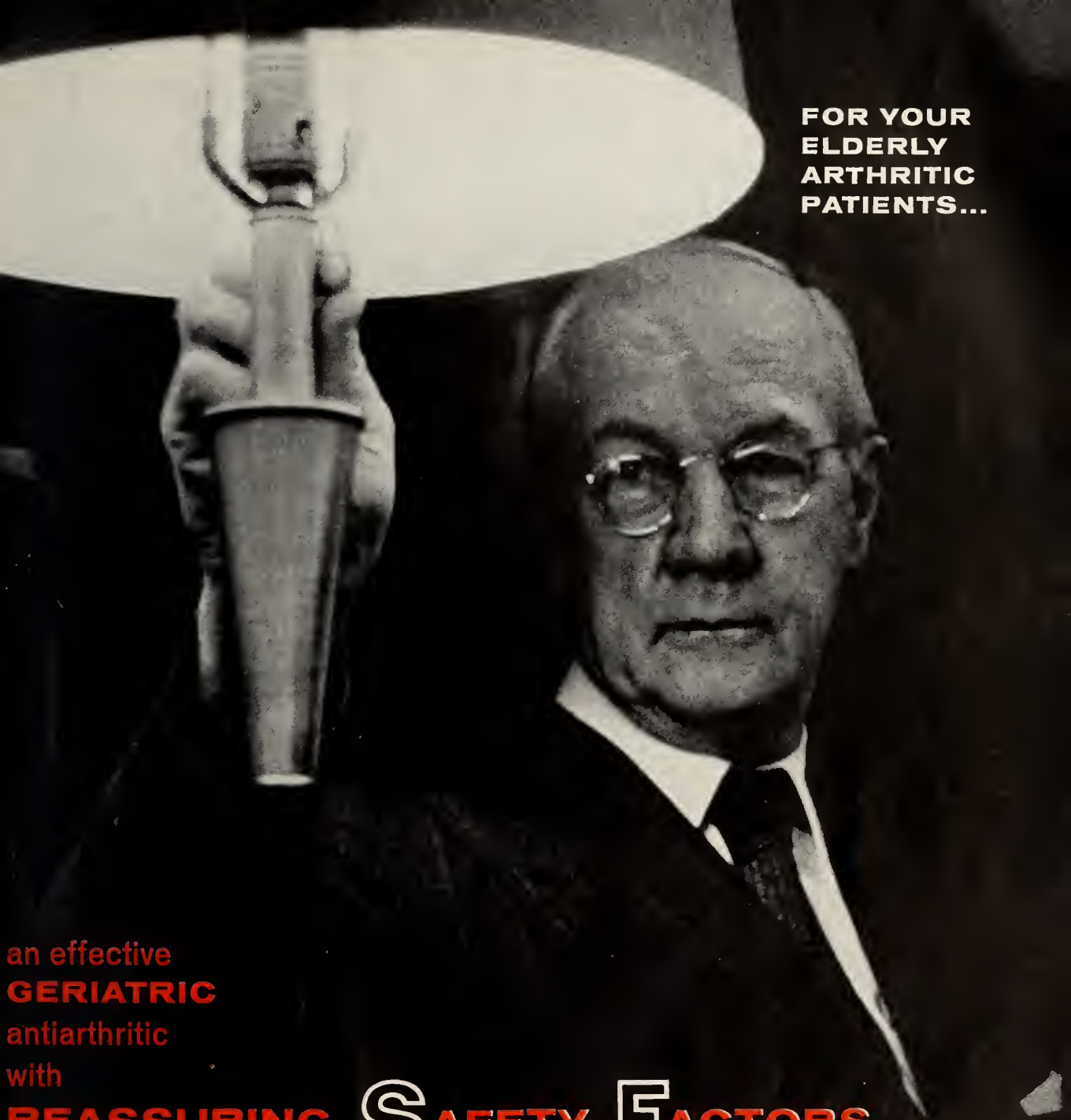
Pathilon® Sequels® with Phenobarbital Sustained Release Capsules

Each capsule contains: Tridihexethyl chloride, 75 mg., and phenobarbital, 45 mg.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle

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FOR YOUR ELDERLY ARTHRITIC PATIENTS...

an effective **GERIATRIC** antiarthritic with

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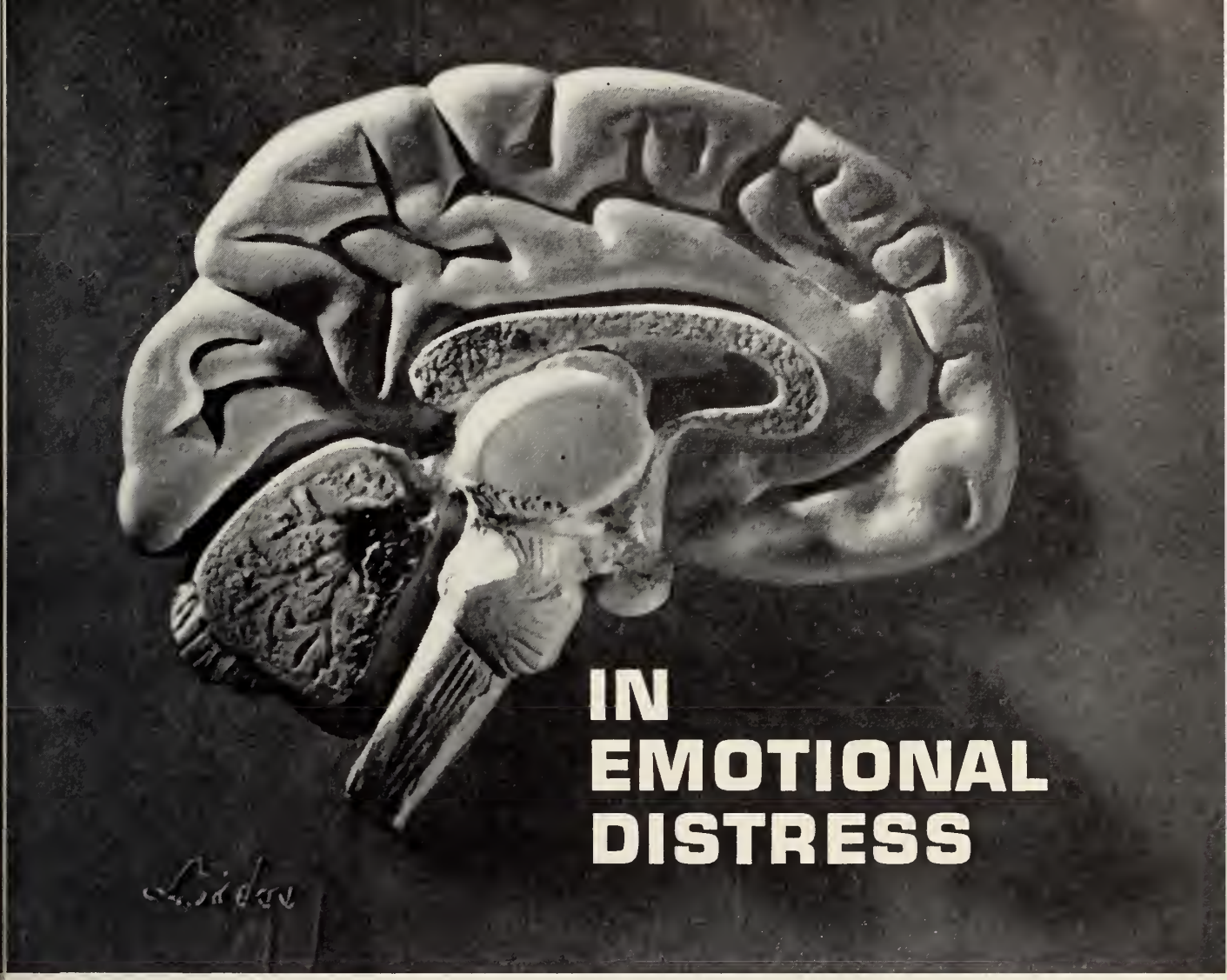
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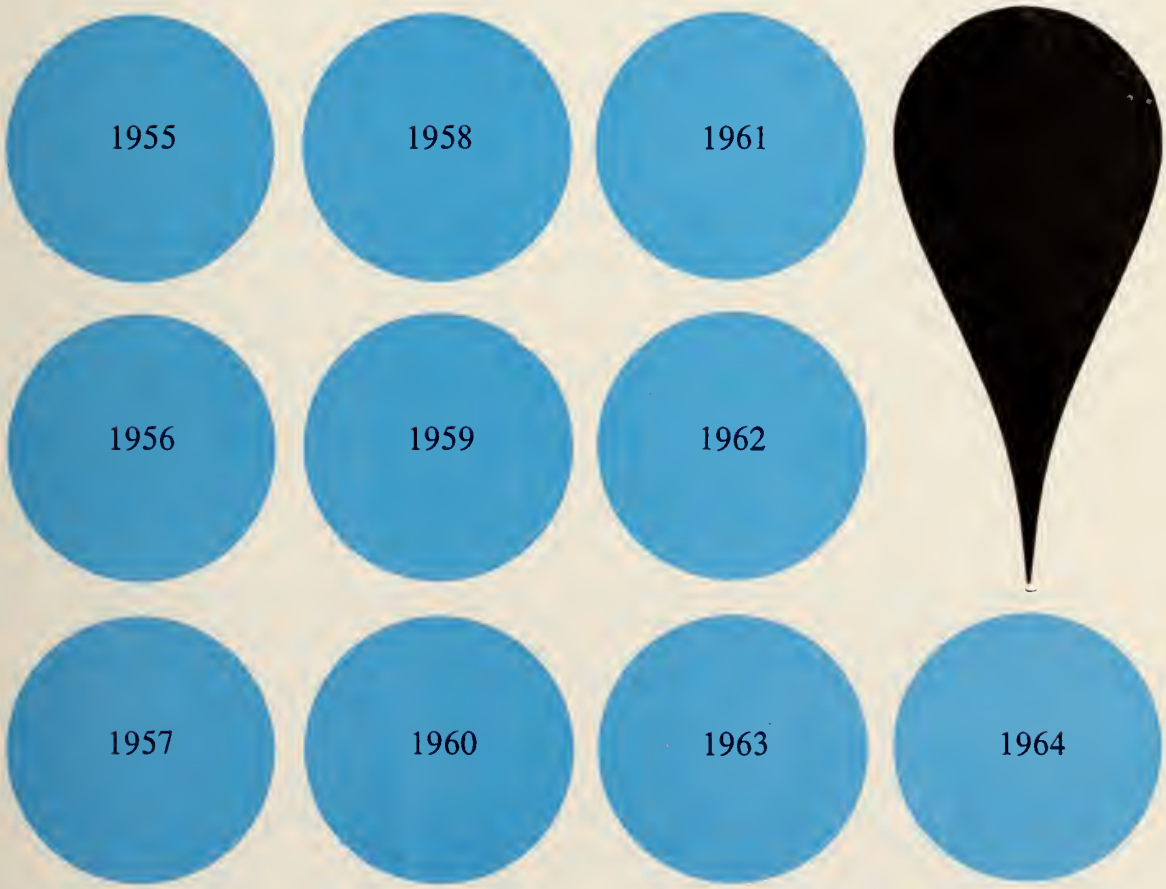
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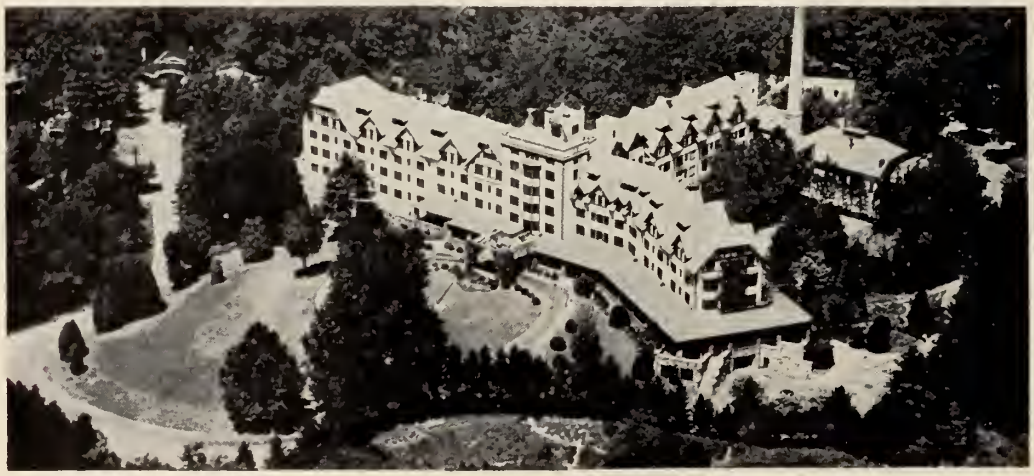
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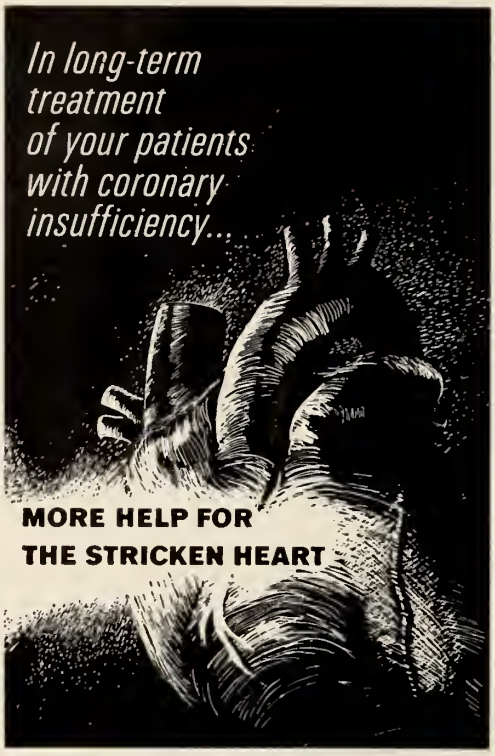
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1. Viglione, J.P.: Clin. Med. *69*:1157 (May) 1962.

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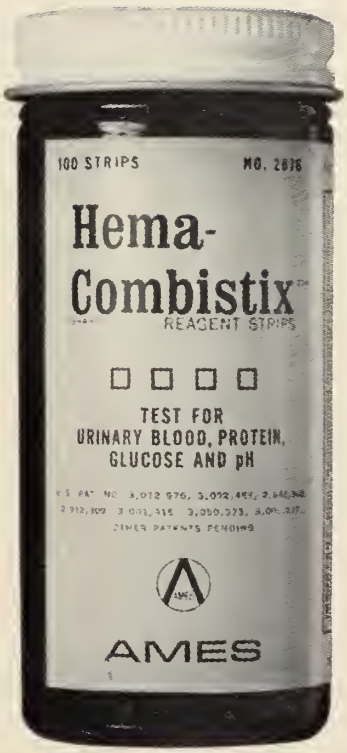
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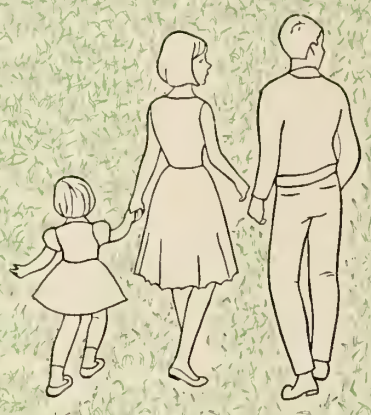
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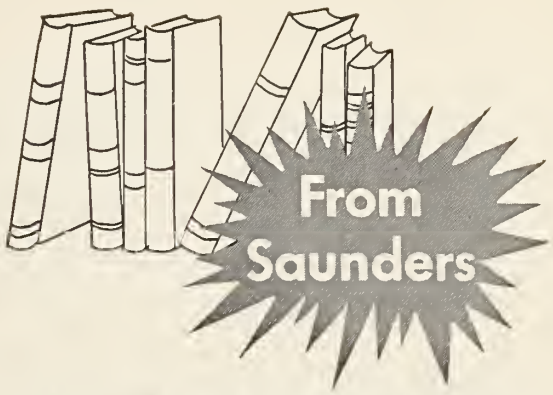
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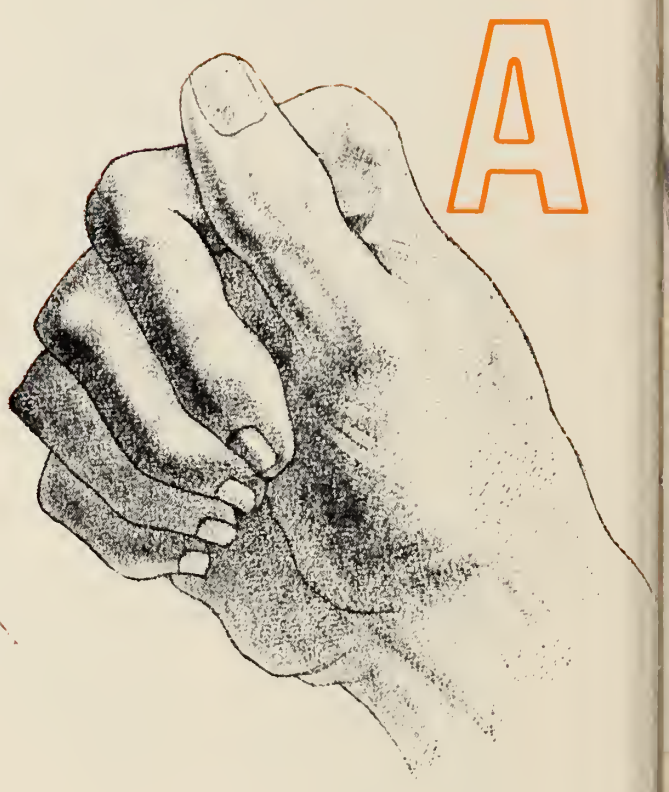
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Ascorbic acid (Vitamin C)	25 mg.
Prednisone	1 mg.

The basic Arthralgen formulation plus prednisone is indicated for patients who require steroids. Prednisone has three advantages over cortisone, hydrocortisone, and ACTH. They are: (1) lack of sodium retention, (2) absence of increased potassium excretion, and (3) the unlikelihood of steroid-induced hypertension.*

BRIEF SUMMARY

Arthralgen and Arthralgen-PR are indicated in the management of rheumatoid arthritis, acute

arthritic joints from



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N



uty arthritis, rheumatoid spondylitis, osteoar-itis, bursitis, fibrositis, and neuritis. Arthralgen ay be used for analgesia in colds, flu, and rious myalgias.

OSAGE: One or two tablets four times a day. ter remission of symptoms, dosage should be duced to the minimum maintenance level.

DE EFFECTS: Nausea, GI upset, or mild salicy-sm may rarely occur. Symptoms of hypercorticoid-m dictate reduction of dosage of Arthralgen-PR.

RECAUTION: Reduction in dosage of Arthral-en-PR given over a long period should be gradual, ever abrupt.

ONTRAINDICATIONS: Hypersensitivity to any gredient.

s with any drug containing prednisone, Arthral-en-PR is contraindicated, or should be adminis-tered only with care, to patients with peptic ulcer, tuberculosis, nephritis, diabetes mellitus, acute psychoses, Cushing's syndrome (or Cushing's disease), overwhelming spreading (systemic) infection, or predisposition to thrombophlebitis.

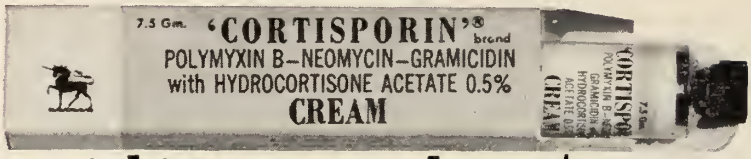
Arthralgen-PR is generally contraindicated in patients with uremia and viral infections, including poliomyelitis, vaccinia, ocular herpes simplex, and fungus infections of the eye. It is also contraindicated in patients with chicken pox or susceptible persons exposed to it.

SUPPLY: Arthralgen (white, scored) and Arthralgen-PR (yellow, scored) tablets are available in bottles of 100 and 500.

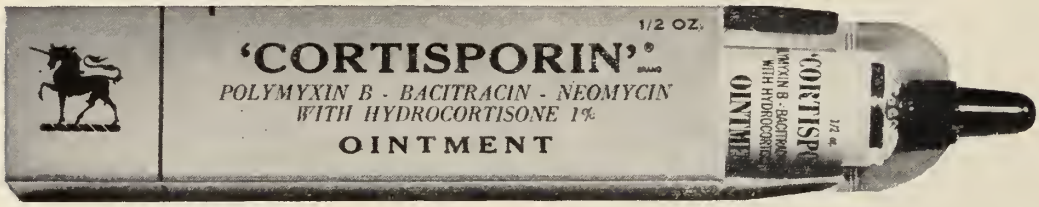
*Cohen, et al: J.A.M.A., 165:225, 1957.

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CREAM—*Ingredients:* Each gram contains 'Aerosporin'® brand Polymyxin B* Sulfate 10,000 Units; Neomycin Sulfate (equivalent to 3.5 mg. Neomycin Base) 5.0 mg.; Gramicidin 0.25 mg.; Hydrocortisone Acetate 5.0 mg. (0.5%).

In a smooth, white, water-washable vanishing cream base with a pH of approximately 5.0. Inactive ingredients: liquid petrolatum, white petrolatum, propylene glycol, polyoxyethylene polyoxypropylene compound, emulsifying wax, distilled water, and 0.25% methylparaben as preservative.

Available: In tubes of 7.5 Grams.

OINTMENT—*Ingredients:* Each gram contains 'Aerosporin'® brand Polymyxin B* Sulfate 5,000 Units; Zinc Bacitracin 400 Units; Neomycin Sulfate 5 mg. (equivalent to 3.5 mg. Neomycin Base); Hydrocortisone 10 mg. (1%).

In a special white petrolatum base.

Available: In tubes of ½ oz. and ⅛ oz.

*U.S. Patent Nos. 2,565,057–2,695,261

Indications: Wherever inflammation or infection occurs and is accessible for topical therapy.

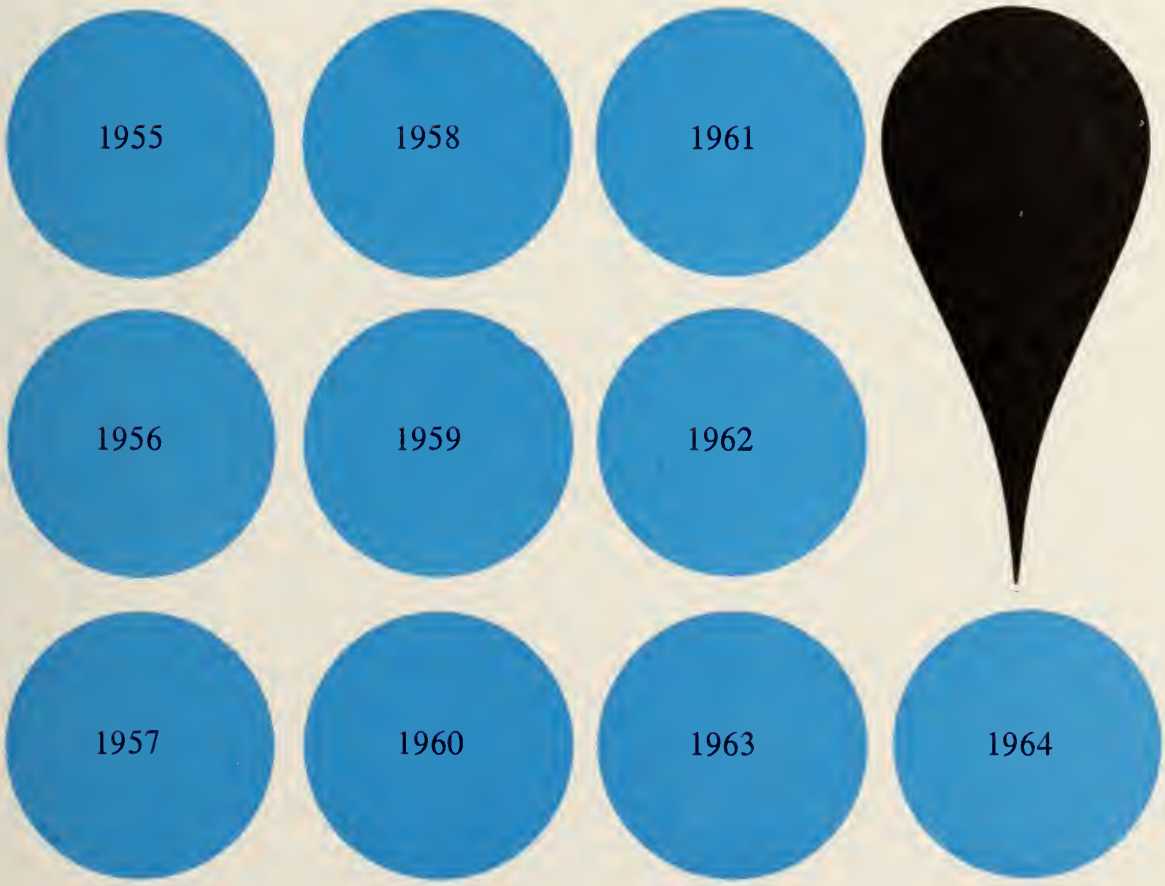
Contraindications: These drugs are contraindicated in tuberculous, fungal or viral lesions (herpes simplex, vaccinia and varicella).

Caution: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

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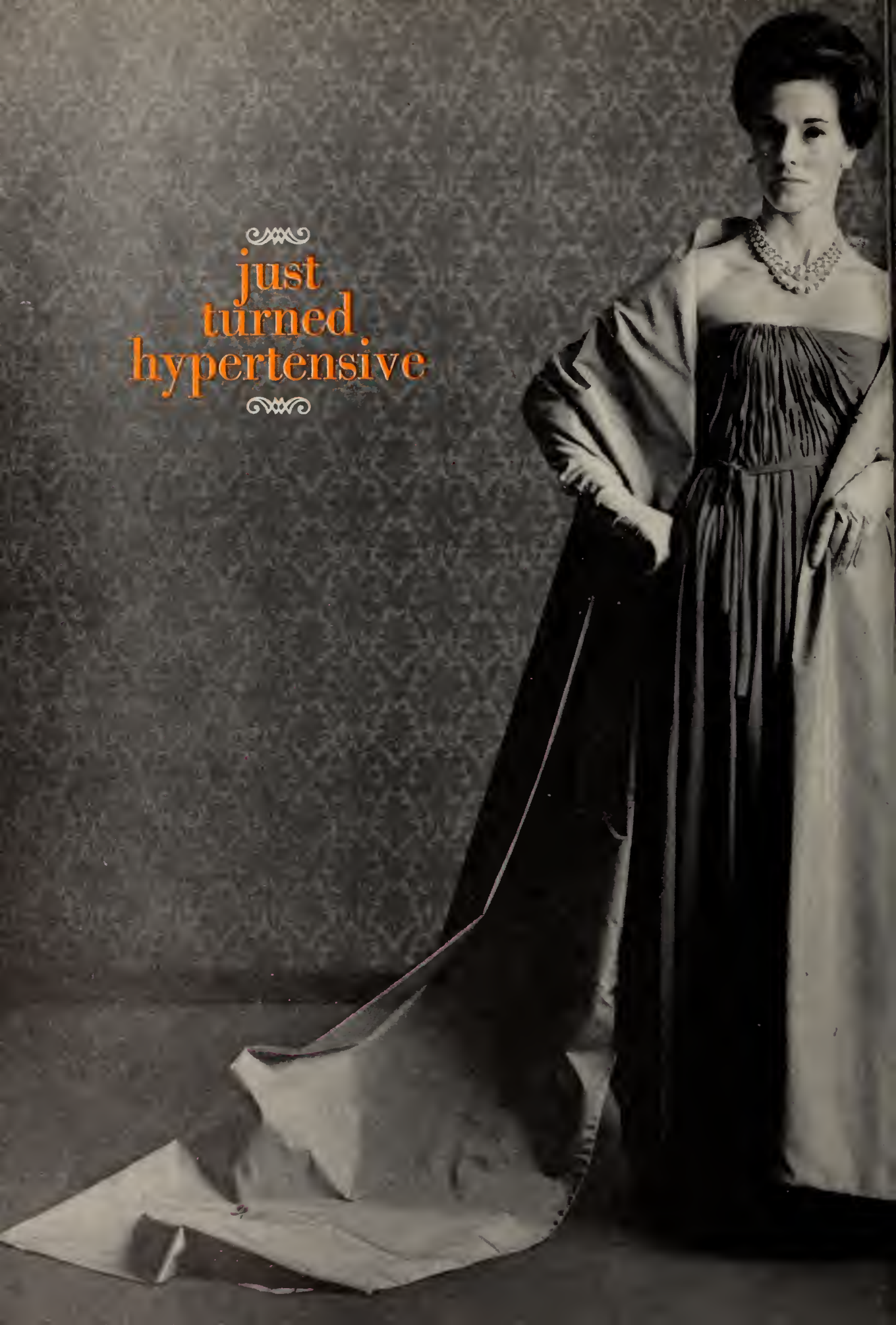


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INDICATED in hypertension with or without edema, and in all types of edema involving salt retention. May be helpful in some cases of lymphedema, idiopathic edema and edema due to venous obstruction.

SIDE EFFECTS: Skin rash (rare), gastrointestinal disturbances, weakness and dizziness, seldom so severe that drug should be stopped. Generally, the adverse effects sometimes associated with the thiazide diuretics are possible. Pre-existing electrolyte abnormalities may be aggravated.

CONTRAINDICATION: Anuria.



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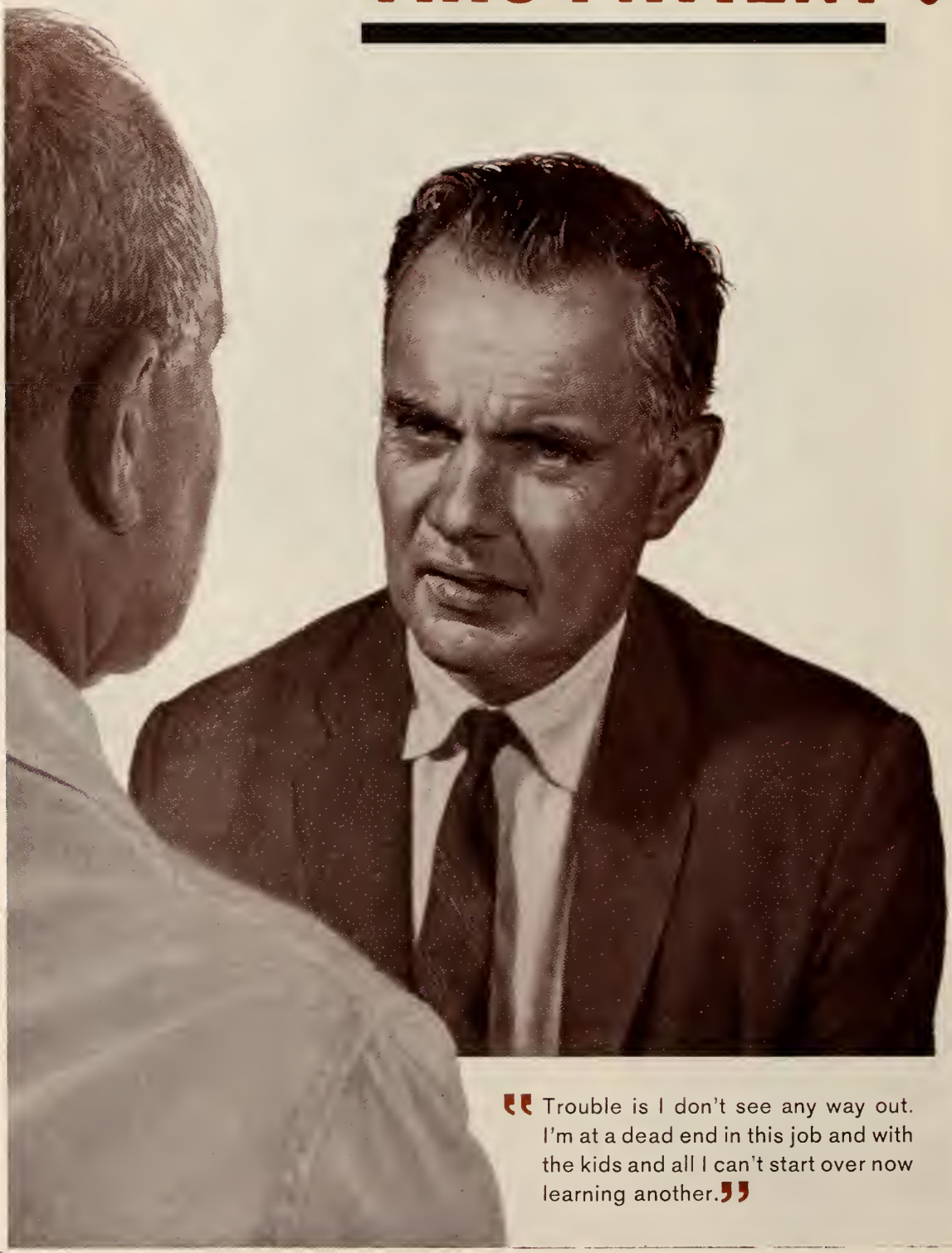
Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive. **Side Effects** typical of tetracyclines which may occur: glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms. Also: photodynamic reaction (making avoidance of direct sunlight advisable) and, very rarely, anaphylactoid reaction. Reduce dosage in impaired renal function. The possibility of tooth discoloration during development should be considered in administering any tetracycline in the last trimester of pregnancy, in the neonatal period, and in early childhood. *Capsules,* 150 mg. and 75 mg. of demethylchlortetracycline HCl. *Average Adult Daily Dosage:* 150 mg. q.i.d. or 300 mg. b.i.d. 1. Sweeney, W. M.; Dornbush, A. C., and Hardy, S. M.: Demethylchlortetracycline and Tetracycline Compared. Relative *in vitro* Activity and Comparative Serum Concentrations During 7 Days of Continuous Therapy. *Amer. J. Med. Sci.* 243:296 (Mar.) 1962.

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Side effects: Slight drowsiness and, rarely, allergic or idiosyncratic reactions, due to meprobamate, and occasional dizziness or feeling of depersonalization in higher dosage, due to benactyzine, may occur. **Contraindications:** Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use of meprobamate or meprobamate-containing drugs. **Precautions:** Should administration of meprobamate cause drowsiness, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Although suicides with 'Deprol' have not been reported, prescribe cautiously and in small quantities to patients with suicidal tendencies. Massive overdosage of meprobamate may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Even though it has not been reported with 'Deprol', consider the possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage. *Complete product information available in the product package, and to physicians on request.*

Usual adult dosage: 1 tablet t.i.d. or q.i.d. May be increased gradually, as needed, to 6 tablets daily. With establishment of relief, may be gradually reduced to maintenance levels. **Supplied:** Light-pink, scored tablets Bottles of 50.

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THE JOURNAL
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Vol. 34 August 1964 No. 2

A NEW HYPOTENSIVE DRUG COMBINATION
(guanethidine-hydrochlorothiazide)

F. BERNARD SCHULTZ, M. D., F. A. C. C.

Auburn, Alabama

Although guanethidine and hydrochlorothiazide may no longer be considered new agents in antihypertensive therapy, their combination in a single tablet may, in a sense, be considered new. The combination tablet has provided, in addition to effective therapeutic activity, a much-needed simplicity of administration in antihypertensive therapy. A report of a comparative study of this new combination preparation appears below.

One might question the need for combining two tried hypotensive drugs which have proved themselves separately. However, as the investigator mentioned in an earlier study in 1961: "The basic problem in the treatment of hypertension is to establish a satisfactory adjustment between the patient's pressure, his medication, and the environment in which the patient must function."[1]

Complete control of blood pressure is impractical if the achievement incapacitates the patient. By the same token, if the patient mistakenly takes the wrong medication because of the variety of different tablets he must remember to take, poor therapeutic control or the possibility of dire consequences as a result of the error could be an inevitable result. On the other hand, when a patient is instructed to take one, two, or three tablets of the same medication, more accurate control of his progress can be maintained by the physician and the patient can follow his dosage regimen more easily and simply.

To simplify and ease this medical and patient problem and reduce to a minimum the previously mentioned dire possibilities, 10 mg. of guanethidine (Ismelin® CIBA) and 25 mg. of hydrochlorothiazide (Esidrix® CIBA) were combined in one tablet by the manufacturer.

The pharmacology of guanethidine was first described by Maxwell et al.[2] Since that time, many investigators, too numerous to mention, have shown clinically that guanethidine is an effective, potent, hypotensive agent

TABLE I
(Initial Findings)

Patient No.	Age	Sex	Weight	Supine B. P.	Supine Pulse	Standing B. P.	Standing Pulse	All patients with the exception of No. 21 and 23 were started on one tablet after breakfast.
1	43	F	127½	182/120	84	160/120	96	
2	65	F	117	146/104	84	174/102	96	
3	60	M	185	160/94	60	146/94	72	
4	43	M	227	168/118	84	170/124	96	
5	62	M	163	150/108	66	140/110	84	
6	50	F	193	174/110	78	156/112	73	
7	73	M	162½	192/94	60	178/88	68	
8	54	M	191	160/108	84	164/98	96	
9	38	M	204	168/98	74	150/96	78	
10	48	F	125¼	160/100	64	140/102	68	
11	70	F	169	220/160	72	210/160	84	
12	61	F	233½	218/110	60	192/120	60	
13	64	F	202	208/106	60	168/118	74	
14	72	F	165½	168/104	66	162/112	78	
15	63	F	207½	146/94	72	128/106	78	
16	66	F	109½	162/68	72	124/70	72	
17	65	F	150	184/98	84	172/96	78	
18	48	F	205	164/102	84	142/92	96	
19	61	F	206½	148/108	66	124/100	78	
20	42	F	137	178/120	90	160/124	96	
21	39	F	145	210/150	78	198/142	102	—started on three tablets daily
22	67	M	125	160/80	60	140/90	66	
23	38	F	182½	206/128	84	192/124	90	—started on two tablets daily
24	35	M	204	174/76	74	160/106	84	
25	57	M	204	224/104	78	204/88	102	
26	47	F	243	164/102	84	140/92	102	

which demonstrates little or no toxicity or tolerance.

Esidrix® is a 6 chloro-7-sulfamyl 1-3, 4-dyhydro 124-benzo thiadiazine-1, 1-dioxide. Pharmacologically it has been shown that this drug provides a dual effect—(a) a reduction in blood pressure, and (b) an increase in renal blood flow.[3]

Reason for Study and Patient Selection

The specific purpose of this study was to evaluate a combination of both drugs in a single tablet as compared to individual tablets of Ismelin® and Esidrix®.

Twenty-six patients with arterial hypertension were selected and observed who had been and were being treated with Ismelin® and Esidrix® (as separate tablets). There were nine males and 17 females ranging in age from 35 to 73. Table I depicts the age, weight, sex distribution, and the severity of hypertension. Table II shows the results and dosages after one month of medication. Table III shows established maintenance dosages and the results at the completion of the study.

All patients, with the exception of numbers 21 and 23, were started on one combination

TABLE II

Patient No.	Sex	Weight after 1 mo.	Supine B. P. after 1 mo.	Supine pulse after 1 mo.	Standing B. P. after 1 mo.	Standing pulse after 1 mo.	Ismelin-Esidrix dosage after one month Daily Dosage
1	F	127½	132/100	84	126/104	84	one tablet
2	F	116	142/98	90	136/103	102	one tablet
3	M	179	172/98	60	164/100	66	one tablet
4	M	227½	162/112	84	190/120	96	two tablets
5	M	162	174/112	66	140/108	74	one tablet
6	F	194	186/110	72	182/120	84	two tablets
7	M	160	156/74	66	128/80	78	one tablet
8	M	192	180/90	88	168/96	96	two tablets
9	M	205	160/94	84	150/102	90	one tablet
10	F	125	162/88	60	156/98	74	one tablet
11	F	166	198/112	72	194/113	72	two tablets
12	F	227	146/102	78	132/98	90	one tablet
13	F	198	168/108	66	132/100	78	one tablet
14	F	161½	172/92	60	146/98	84	one-half tablet
15	F	207	150/94	72	130/100	78	one tablet
16	F	110	190/92	66	182/96	72	two tablets
17	F	147½	150/88	78	132/88	84	one tablet
18	F	207	176/104	78	142/108	90	one tablet
19	F	200¼	140/98	60	124/100	78	one tablet
20	F	137¾	178/118	96	152/110	90	two tablets
21	F	144	196/118	72	176/140	96	two tablets
22	M	120	140/78	84	124/92	96	one tablet
23	F	185	194/118	84	182/130	96	three tablets
24	M	201½	188/132	60	174/132	78	three tablets
25	M	197	180/78	54	180/82	60	two tablets
26	F	243½	158/110	78	124/104	84	one tablet

tablet after breakfast. Patient numbers 21 and 23 were started on two tablets a day because of their high level of hypertension and mental state.

Following subsequent examination of all the patients, dosages were either increased or decreased according to their progress or lack of progress. Patients were checked in both the supine and standing positions. The general examination trend demonstrated a drop in the systolic pressure and increase in the diastolic pressure from supine to the standing position together with an increase in the pulse rate.

Discussion

As may be seen in Table III the results obtained from the combination of Ismelin® and Esidrix® were exceptionally good. The direct action of Esidrix® was excellent and reached its maximum effect on or about the second day after initial treatment. Thereafter, patients maintained a normal urinary output with neither signs nor symptoms of serious electrolyte loss.

None of the patients in this group showed any marked tolerance or resistance to either drug.

TABLE III

Patient No.	Sex	Weight	Supine B.P.	Supine Pulse	Standing B.P.	Standing Pulse
1	F	126½	156/108	72	132/110	84———one tablet
2	F	114	140/98	78	134/106	84———one tablet
3	M	175	148/86	60	136/88	74———one tablet
4	M	227	154/100	86	150/112	96———two tablets
5	M	163	160/110	78	152/112	84———one tablet
6	F	193	194/120	72	182/128	84———three tablets
7	M	161	160/86	60	158/84	66———one tablet
8	M	184	164/94	74	140/94	78———two tablets
9	M	202½	138/88	78	136/88	78———one tablet
10	F	124	158/88	66	144/94	78———one tablet
11	F	162½	160/108	68	158/110	78———three tablets
12	F	228	150/106	66	144/104	72———two tablets
13	F	198	168/108	66	132/100	78———one tablet
14	F	164½	144/82	66	144/98	78———one-half tablet
15	F	208½	142/86	72	132/84	80———one tablet
16	F	109	180/90	60	160/82	74———two tablets
17	F	152	150/90	66	130/86	84———one tablet
18	F	207	176/104	78	142/108	90———one tablet
19	F	203	140/96	60	136/98	78———one tablet
20	F	137	182/114	84	156/100	92———one tablet
21	F	147	178/132	72	162/120	84———three tablets
22	M	118	132/74	52	126/76	60———one tablet
23	F	187	162/100	96	142/108	108———two tablets
24	M	198½	164/108	60	160/110	74———three tablets
25	M	204	190/90	64	176/80	72———two tablets
26	F	246½	160/104	78	144/100	84———one tablet

All patients, with the exception of No. 21 and 23, initially received one tablet a day. Since their initial hypertensive levels were 210/150 and 206/128 in the supine position respectively, it was felt that in order to bring them to a fairly well controlled level, a dosage of three tablets daily was necessary. Although there was a short period where patient No. 21 was placed on two tablets a day, it became necessary to return to a dosage of three tablets a day because of her hypertensive state. As of this writing, she has had no further complaints and is being well maintained on this dosage.

If one were to examine our patient records, a question could be raised as to why patients number 11, 12, 13 and 25 were not started on as high a dosage as the above two. Since these patients did not show any of the signs of apprehension or complain of severe headaches which Numbers 21 and 23 did, we did not feel it was necessary.

It can be noted that a number of these cases with quite high systolic and diastolic levels were controlled on one tablet daily. However, in other instances, there were patients who required an increased dosage level in order to be maintained.

This brings us to the inevitable conclusion that in the treatment of hypertension or, for that matter, any disease state, if one wishes to treat patients with any success, one must treat them individually. In this investigator's opinion, it is better gradually to increase dosages rather than start at high dosages and work one's way down. In this manner, side effects are more readily discernible and better results are obtained.

Side effects such as nasal stuffiness, nausea, diarrhea, and impotence noted by other investigators with these drugs were noticeably lacking in this study. Moreover, it might be appropriate to mention that in previous studies and in a long-term study of Ismelin® no serious side effects have ever been encountered by this investigator.[4]

Summary

Twenty-six patients were treated for a period of three months with a combination of Ismelin® and Esidrix® tablets. This new combination tablet was found to be well tolerated and gave good to excellent results with adjusted dosages. The combination proved as effective as both agents given separately. There were no side effects of any consequence.

We would recommend the use of this combination either alone or as a maintenance dose in hypertensive patients, with the proviso, of course, as with *all* medication, the patient remains under his physician's continuous observation and care.

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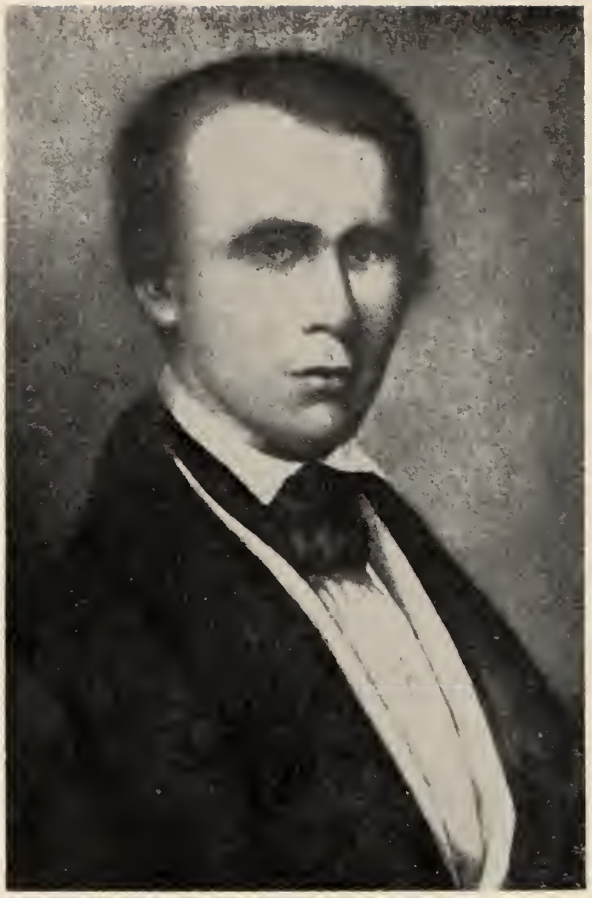
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JOHN YOUNG BASSETT--- *The Alabama Student*

EMMETT B. CARMICHAEL

The subject of this biographical sketch was the inspiration for an essay by Dr. William Osler* which almost immortalized Dr. John Y. Bassett. Osler (1896) was not only impressed favorably with Bassett's style of writing but also by the fact that he left a growing practice of medicine in a frontier town to do postgraduate study in Europe with the leading physicians and surgeons. The custom of doing postgraduate study in Great Britain, France, and Germany became quite the thing to do during the last quarter of the 19th century and the first few years in this century.

The Bassett family immigrated to this country in the 18th century. Isaac Bassett, the father of John Young, married Naniela Davidson, daughter of General William Lee Davidson who fell at Catawba Ford in the Battle of Cowpens, South Carolina. Isaac and his wife settled in Baltimore and began their married life when Napoleon was ravag-

Dr. Carmichael is Assistant Dean, University of Alabama Medical Center, Birmingham, Alabama.

*Dr. William Osler received his Baronetcy in 1911.

ing most of Europe. Five children were born to this union: Henry Willis, William, John Young, Frank, and Margaret. The two older boys, Henry Willis and William, were both impatient for life. Henry Willis was anxious for adventure and signed on a ship when 17 and made a voyage around the world. William was for adventure wherever he found it, on sea or shore, but his passion was for books. When he was not roistering and roving, he was absorbed in books, history, poetry, science, and, later on, political economy. William was against organized authority, whatever it was.

The third son, John Young, was of a different temperament from his two older brothers. He was quiet, more studious, graver, more sober, and much gentler with his mother than the older brothers. John stayed at home and from early childhood he expressed a desire to become a musician.

John's father, Isaac, died in his early forties in Baltimore. He had not accumulated a great deal of wealth so the boys helped support the family. At fifteen, John apprenticed himself to Samuel Sweetwater, a druggist in Baltimore, and for five years worked by day but read and studied at night. After five years of apprenticeship he continued another year on a salary. The next year, he along with a Dr. Hammond opened a drug store in Baltimore. Later on he became the sole proprietor and sold the store so that he could begin the study of medicine.

Washington Medical College (Reorganized in 1867 and merged with the College of Physicians and Surgeons of Baltimore in 1877 and became part of the University of Maryland in 1878) was founded in 1827 and John Young Bassett received his diploma in 1828.

He came to Alabama just a few years after she joined the Union and opened his office in Huntsville. He brought his younger brother, Frank, with him and they opened up a drug store. Frank was the apothecary while John combined the practice of medicine with the selling of drugs. Frank met with an accident while hunting, and lost his life from tetanus induced by the bursting of his gun. The drug store passed into other hands and Dr. Bassett became one of the regular physicians of Huntsville. At that time, Huntsville was one of the most refined communities in the South. Many of its citizens were wealthy planters whose plantations were located in Louisiana and Mississippi as well as in Alabama. They elected to live in Huntsville because of its beautiful climate and because of the educational advantages offered by the schools. Many of the boys attended Harvard, Yale, Princeton, and the University of Virginia.

Dr. Bassett's practice grew as he was a tireless worker. However, he did find time to meet the young ladies of the community and in 1831 he married Isophoena Thompson, daughter of Dr. Asa Thompson, wealthy country doctor and planter.

In 1835, with his practice increasing and his desire to excel in the treatment of his patients, he made plans to go to Europe to study and practice in the leading clinics and hospitals in England, Scotland, France, and Germany. His friends questioned the wisdom of his leaving his wife, his small sons, and his practice which had been growing very well.

In spite of the disadvantages he went ahead with his plans to go to Europe. He left Huntsville on horseback by way of Nashville for the state of Illinois where he visited at Edwardsville and Vandalia. His letter of October 15, 1835 was written on the steamboat "Chancellor" on the Mississippi River. He stopped over in Louisville and Cincinnati where he heard Dr. Daniel Drake lecture and made the following comment: "I am delighted with Dr. Drake's manner as a lecturer." He visited in Philadelphia for a few days and spent ten days in New York City before sailing on the "Roscoe" on January 10, 1836 bound for Liverpool. He visited Manchester, York, Edinburgh, Glasgow, Belfast, and Dublin before going to London. After two weeks in London he took passage to Paris.

Dr. Bassett attached himself at once to the clinic of Velpeau at La Charite' and learned that there were many Americans studying at the various clinics and schools in Paris. He began dissections at once and attended lectures. He often gave detailed accounts of his experiences in his letters to his wife and in the one dated March 16, 1836, mentioned his daily routine: "I get up in the morning at six o'clock and am at La Charite' by seven, follow Velpeau until eight, see him operate and lecture until after nine, breakfast at ten at a cafe. At eleven I am at the school of practical anatomy, where I dissect until two. Then I attend a class of practical surgery until three, then hear Broussais and Andral until five, then dine. At seven I attend Helmagrande's class of midwifery, which lasts until nine, then I come to my room and read or write until eleven, when I retire."

Apparently, Bassett had occupied his time to good advantage since in early July, he received from Velpeau the appointment of externe at La Charite'. The duties of externe required him to be at the hospital at six o'clock, answer to his name, follow the surgeon around a certain number of beds, attend to his prescriptions and dress the patients. For this service he received no pay. He wrote his wife concerning the appointment: "I was on the eve of starting for Switzerland but when the offer was made me, I did what I have been doing all my life, made another sacrifice for my profession and I am determined to remain and take the service. I have not been more gratified since I have been in Europe; it is a real benefit and came unsolicited."

His last letter was dated October 16, 1836 and mentioned his approaching departure for home and that he intended to be back by the first of the year.

Before Dr. Bassett went to Europe, his practice was adequate for his family and personal needs but because he was a stranger without prestige of name or fortune, he really had a rough time. It seems that the firm of Fearn, Erskine, and Russel catered to the wealthier families while Bassett drew his security support from the denizens of the hills and hollows of the surrounding country. However, after his training in Europe, things changed. People were inclined to think that a man who had studied in London and Paris knew more than other physicians and so it was with Dr. Bassett. He gradually was brought into a better class of practice because of "consultation," called for by other physicians. His knowledge of anatomy and his ability as a surgeon soon gave him the surgical cases of that section of the country and he soon became the recognized surgeon of North Alabama.

As he became more prosperous, his first thoughts were for the comfort of his wife and children. He built one of the nicest homes in Huntsville. The house is still in good repair and is the residence of one of Dr. Bassett's great granddaughters.



Bassett Home

Later on he sent for his mother and sister, Margaret. Margaret, a maiden lady, apparently had been quite popular in Baltimore with the younger set which included Edgar Allen Poe and his older brother, Henry. Margaret, a woman of education, dis-

appointed hopes and endowed with a liberal share of bitter sarcasm, stirred up strife in the community and John had to bear the brunt of it all.

A few weeks before his mother came to Alabama, she received the news that her eldest son, Henry Willis, who was the surgeon on the U. S. war ship, "Vandalia," had been killed in a duel at Rio de Janeiro. Henry was a young lieutenant and fell at the first shot and died within 30 minutes.

John Young was an unusual character. Being a Bassett, he was never content with accepting any condition as he found it just because it existed. There was slavery, religion, quackery, and professional stupidity. Sooner or later he would ridicule each of their weaknesses. He outraged the institution of slavery. His friends and associates felt that he did not have the proper reverence for the church and religion because he questioned many of its established rights. The law because it was the law and the government because it was the government was not enough so he probed at them too. He was a pioneer in various areas and was well in advance of the thought and medical science of his environment.

Dr. Bassett was a man of his convictions. He demonstrated this quality during the 1840's when the abolitionists in Scotland and Ireland joined with the Presbyterian Synod in America in denouncing slavery. The reports of the actions of the people from the foreign countries and the local church group appeared in the Huntsville papers beginning in 1846. Dr. Bassett took issue with the reports and especially with the local Presbyterian minister who seemed to be a self-appointed committee of one to abolish slavery. Dr. Bassett authored a series of articles for the local Huntsville papers and signed them with the pen name or initials J. G. R. From the content and style of the other articles in the local press, it appears that he used other pen names which helped him to keep the issue of slavery before the public. These articles appeared in both *THE DEMOCRAT* and the *SOUTHERN ADVOCATE*, Huntsville, Alabama in 1848. During the same period, Dr. Bassett also wrote several small articles to the editors of the paper and signed his own name. It seems that as the controversy became quite heated, Reverend C. P. Wing discovered that the articles signed J. G. R. were written by Dr. Bassett and so stated the fact in a rebuttal article.

The clippings of the articles of the above controversy apparently were saved by Dr. Bassett and many of them were pasted in a book. On April 6, 1848, Dr. Bassett presented another article to the Editor of *THE DEMOCRAT* but withdrew it when he found that the Reverend Wing had left town precipitously without taking care of his financial affairs. The longhand article appears in the clipping book along with the explanation that there was no need for its publication since Reverend Wing had departed.

Dr. Bassett took an active interest in organizing the Medical Society of Madison County, Alabama. The September 5, 1848, issue of the *SOUTHERN ADVOCATE* under the following headline, "To the Medical Profession of Madison County" carried the call to convention. "The practitioners of medicine of Madison County who are graduates of respectable schools and who have not habitually indulged in quackery, are requested to attend a convention to be held in the Federal Court Room at Huntsville, on the first Monday in October, between 10 and 12 o'clock, for the purpose of forming a Medical Society."

At the convention on October 2, 1848, it was unanimously resolved that an auxiliary County association be formed. Dr. Bassett along with four other physicians constituted a committee to make arrangements for the formal organization which was to be governed by the "Regulations" and "Code of Ethics" submitted by the National Medical Convention in May, 1848. Dr. Bassett served as secretary, *pro tem* and later on signed as chairman of the committee.

At the final organization meeting on Monday, November 6, 1848, Dr. Bassett was

elected secretary of the Medical Association of Madison County. Sixteen physicians enrolled as members of the new county association.

Dr. Bassett assumed his obligation to his adopted state and to the union by serving as Surgeon General of First Division Militia, state of Alabama in 1842. He was made a Master Mason in 1842 and was a member of Helione Lodge No. Seven of Huntsville.

It seems that Bassett wrote only two papers and they were printed in Fenners Southern Medical Reports. They are well written and display his great knowledge and wisdom as a dedicated physician. He was a very discreet individual even though he was considered by many to be controversial. In his first report to the Southern Medical Reports on the topography, climate, and diseases of Madison County, Alabama, Dr. Bassett made the following statement concerning some members of the medical profession in his county: "Many of these early doctors are yet living; I have, therefore, avoided mentioning their names, for, like Dr. Atkinson of York, when I speak of doctors, I proceed warily, skimming over them and their names, as if I were kicking a wasp."

Dr. Claudius H. Mastin, in a letter to Dr. Osler dated April 13, 1896, had the following to say about Dr. Bassett: "Having decided to make medicine my profession, I looked around for a preceptor who would work out the proper course for me to take, and, after investigation, I concluded that Dr. John Y. Bassett was, by all odds, the best fitted man in that town (Huntsville) to give me the instruction I required. Thus it was that I entered his office as a pupil in 1846 and remained with him 18 months when he advised me to go to the University of Pennsylvania and gave me a letter of introduction to his personal friend, Professor George B. Wood." Young Mastin made the decision to study with Bassett in spite of the fact that his two brothers had married daughters of two of Dr. Bassett's associates, Dr. Fearn and Dr. Erskine.

Bassett was born when this republic was little more than 25 years old, when politically and socially it was taking its first independent steps as a nation. Napoleon was at the *height* of his fame and was destroying country after country. No doubt the turmoil of the times helped make him an unusual man in many ways. With his drive to be a better physician and surgeon, one wonders how he might have performed in this century with our modern hospitals, equipment, drugs, and vast amount of medical literature.

Dr. John Y. Bassett married Miss Isophoena Thompson on April 21, 1831. They had six children: Henry Willis (who became a physician, married Carrie Neal); Alice (married a Mr. Young); Laura; Leonora; John (died young); and William. In 1851, Dr. Bassett, who had contracted tuberculosis, went to Florida for his health. He returned in the fall and died on November 2, 1851 in Huntsville.

In the preface to his book of biographical essays, Dr. William Osler made the following statement which will hold true for ages to come, "Pictures such as these, detached as many of them are from each other, have but one value to the student—to waken that precious quality of human sympathy which may enable him to appreciate that in the simple annals of such a career as the 'Alabama Student' a life may be as perfect as in a Harvey or a Locke."

Seventy years ago in the last paragraph of Osler's essay, he summed up Bassett's experiences and contributions to humanity and this gave him an opportunity to impart a bit of his own philosophy relative to the "so called" old masters in the medical sciences. ". . . I began by saying that I would tell you of a man of whom you had never heard, of a humble student from a little town in Alabama. What of the men whom he revered, and for whom in 1836 he left wife and children? Are they better known to us? Today scarcely one of those whom he mentions touches us with any firmness from the past.

Of a majority of them it may be said, they are as though they had never been. Velpeau, Andral, Broussais, the great teachers whom Bassett followed, are shadowy forms (almost as indistinct as the pupil), dragged out to the daylight by some laudator temporis acti, who would learn philosophy in history. To have certain ideals—this alone is worth the struggle. Now and again in a generation, one or two snatch something from dull oblivion; but for the rest of us, sixty years—we, too, are with Bassett and his teachers, and

No one asks
Who or what we have been,
More than he asks what waves,
In the moonlit solitudes mild
Of the midmost ocean, have swelled,
Foam'd for a moment, and gone."

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DIET AND ERYTHROCYTE SEDIMENTATION RATE

by

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and

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Introduction

Many physical, chemical, and biologic factors have been shown to affect the erythrocyte sedimentation rate. However, no reference to nutrition can be found in a survey of leading hematology textbooks.[1-7] Actually, it is generally accepted, by act if not by word, that neither malnutrition nor undernutrition (unless very severe) is believed to influence directly the erythrocyte sedimentation rate.

In view of the paucity of information, this report is designed to cast some light upon possible relationships between various nutrients and the erythrocyte sedimentation rate.

Review of the Literature

A more detailed survey of the literature concerning the relationship of nutrition to erythrocyte sedimentation revealed several interesting reports. Rinehart[8,9] has rather conclusively demonstrated that a mixture of ascorbic acid and bioflavonoids significantly lowered the sedimentation rate in both adults and children afflicted with rheumatic fever. The mean reduction at the end of one month was approximately 50 per cent while control patients with rheumatic fever demonstrated no change in sedimentation. Cass and his co-workers[10] noted a considerable reduction of the erythrocyte sedimentation rate after ascorbic acid therapy in elderly arthritics, diabetics, and multiple sclerosis patients.

These observations may be related to a suppression of inflammation since Menkin[11] has reported that water-soluble citrus bioflavonoids are quite potent anti-inflammatory substances. Actually, they are effective, over a larger pH range than either cortisone or corticotropin (ACTH), in reducing capillary permeability.

Walker and his associates of the South

African Institute for Medical Research[12] have noted that, although high sedimentation rates are common among different regional groups of apparently healthy Bantu mine workers, the values are reduced to normal limits after subjects, without medical treatment, have consumed for four to 15 months the excellent diet provided in the mine compounds. They report as follows: "Our results revealed an equal degree of abnormality of erythrocyte sedimentation rate among recruits with and without previous periods of service in the mines. This finding suggests that the normal values found on leaving the mines rise again on returning for some months to conditions of tribal life. The dramatic and unexpected changes in erythrocyte sedimentation rate found in these outwardly healthy subjects are not due to any medical treatment, and we are driven to ascribe the changes directly, or indirectly, to the consumption of an excellent diet for several months. The workers, ranging in age from 18 to 40 years, came from areas where the diet is usually adequate in calories and gross protein, but is low in animal protein, fat and certain mineral salts and vitamins. The mine compound diet, which may be eaten to satiety, is nutritionally adequate."

Method of Investigation

Eighty-four white male presumably healthy junior dental students participated in this study. At the initial visit the erythrocyte sedimentation rate, corrected and uncorrected, was done by the Wintrobe technique.[13] The students were randomly classed into two major groups (Table 1). Group I, consisting of 40 students, was instructed to take a relatively low-refined-carbohydrate (no sugars or white flour products) high-protein diet (increased consumption of meat, fish, fowl, eggs, nuts, and cheese) for three days. Group II (44 students) was randomly divided. Group IIa was given 40 grams of a protein supplement (Table 2) for three days; Group IIb was administered an identical placebo (methylcellulose, 40 grams daily) for the same time period.

Three days later the corrected and uncorrected erythrocyte sedimentation rate was ascertained by the same technician with the same technique.

Results

The participants in Group I receiving a relatively low-refined-carbohydrate high-protein diet for three days did not demonstrate significant changes in uncorrected (Table 3 and Figure 1) or corrected (Table 4 and Figure 2) erythrocyte sedimentation rates. This was true not only for the difference of the means but for the coefficient of correlation between the initial sedimentation rate and the difference after the three-day dietary (Figures 1 and 2).

Although the means were not significantly different (Table 3) in the individuals re-

TABLE 1

groups	number of subjects	treatment regime
I	40	relatively low-refined-carbohydrate, high-protein diet
IIa	22	protein
IIb	22	placebo

TABLE 2

Composition of Protein Tablets

Average weight	760 mg.
Protein content	
derived from	
soybean protein concentrate	
casein	
gelatin	

Essential Amino Acid Content
(per 12 tablets)

Isoleucine	485 mg.
Leucine	715 mg.
Lysine	560 mg.
Methionine	135 mg.
Phenylalanine	450 mg.
Threonine	350 mg.
Tryptophane	95 mg.
Valine	460 mg.

Table 3
uncorrected erythrocyte sedimentation rate

group	sample size	initial values (mean and S.D.)	final values (mean and S.D.)	significance of the difference of the means (P)	coefficient of correlation of the initial scores versus the difference from the initial (r)	significance of the coefficient of correlation (P)
I	40	6.9 ± 6.5	7.4 ± 6.3	=0.500	-0.317	>0.050
IIa	22	6.2 ± 6.7	7.1 ± 5.7	=0.500	-0.520	<0.050
IIb	22	7.7 ± 6.3	8.7 ± 6.9	=0.500	-0.228	>0.200

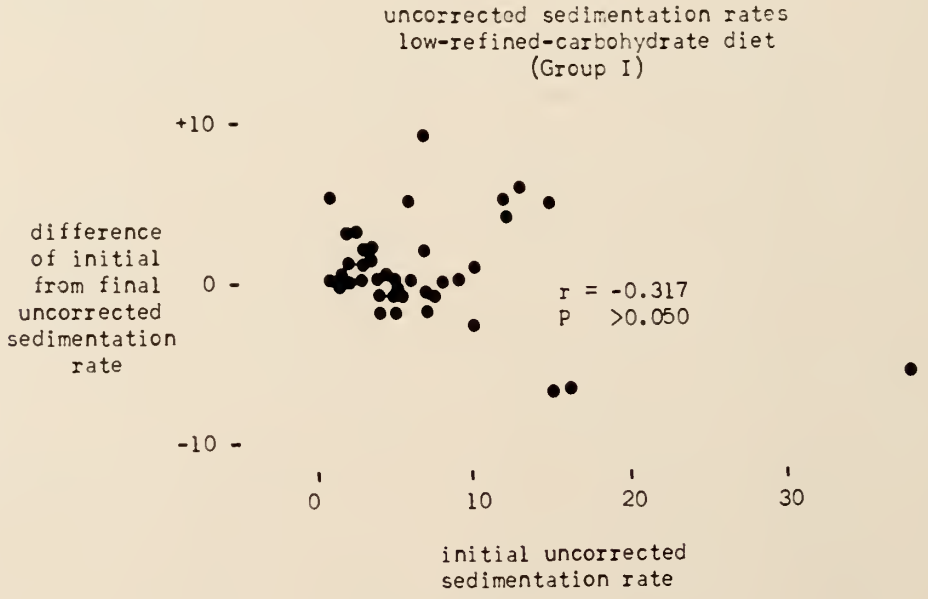


Figure 1

Table 4
corrected erythrocyte sedimentation rate

group	sample size	initial values (mean and S.D.)	final values (mean and S.D.)	significance of the difference of the means (P)	coefficient of correlation of the initial scores versus the difference from the initial (r)	significance of the coefficient of correlation (P)
I	40	9.2 ± 6.1	9.0 ± 6.1	=0.500	-0.321	>0.050
IIa	22	9.2 ± 6.4	9.3 ± 4.7	=0.500	-0.698	<0.005
IIb	22	12.3 ± 6.0	12.0 ± 6.1	=0.500	-0.327	>0.100

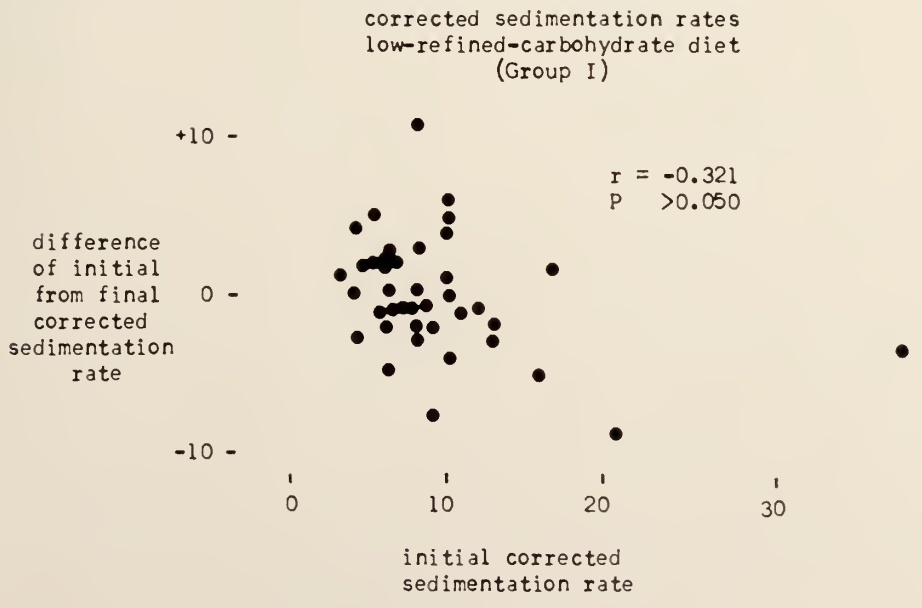


Figure 2

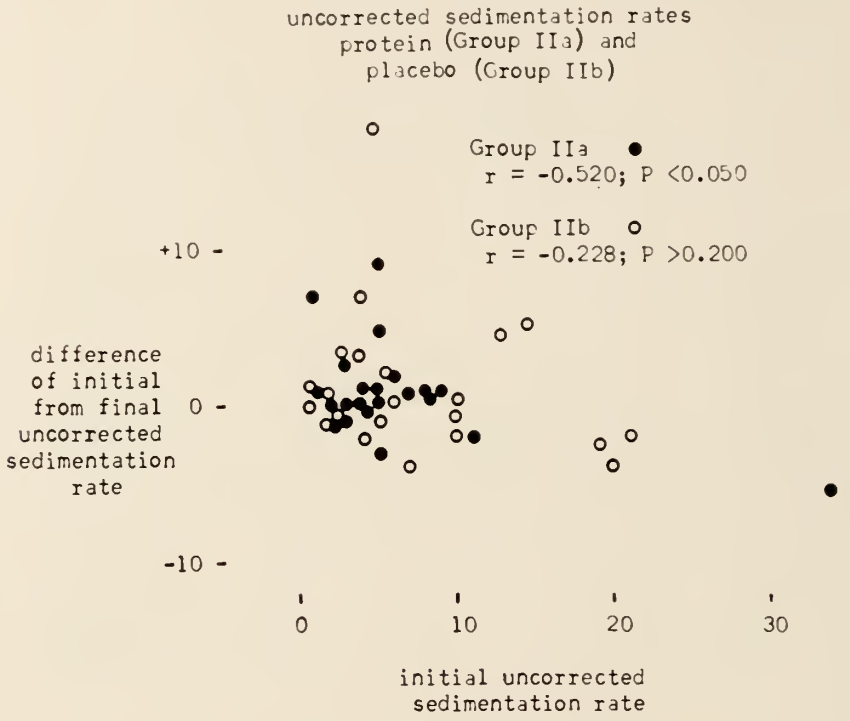


Figure 3

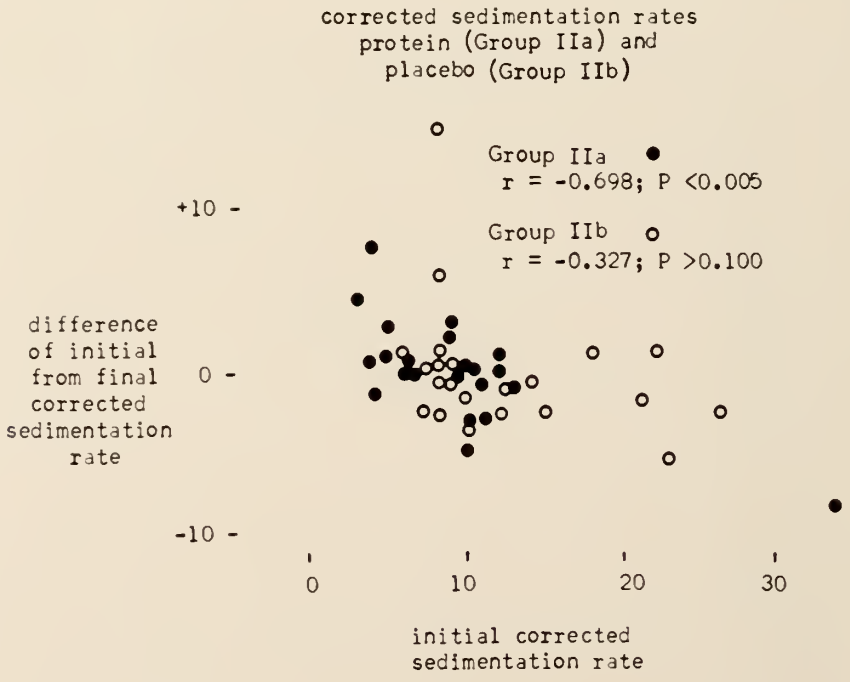


Figure 4

ceiving the protein supplement (Group IIa), an increase in the low sedimentation rates and a reduction of the high values were quite striking. In the main, those scores greater than ten millimeters per hour were reduced and the rates below five millimeters per hour were increased. The consistency of this pattern is reflected by a significant coefficient of correlation for the uncorrected ($r = -0.520$; $P < 0.050$) sedimentation rates in Table 3 and Figure 3 and the corrected ($r = -0.698$; $P < 0.005$) sedimentation rates in Table 4 and Figure 4.

The erythrocyte sedimentation rate of the control group (IIb) did not significantly change following the three days of placebo supplementation. This may be observed for the uncorrected rate in Table 3 and Figure 3 and for the corrected rate in Table 4 and Figure 4.

Discussion

It appears from the results of this study that provision of a balanced essential amino acid formula (40 grams daily) to a group of presumably healthy students produced significant alterations in the erythrocyte sedimentation rate after three days. These changes are not revealed by the difference of the means since very low rates tended to increase slightly and high values decreased. The correlation coefficient, however, between the initial sedimentation rates and the changes after three days was quite orderly and significant. The degree of significance was enhanced when the rate was corrected for the number of erythrocytes (Figure 3 and Figure 4).

Since a double-blind procedure was employed and no significant changes were observed in the placebo group, it is possible that the altered sedimentation in the supplemented subjects was in response to the administered protein. This seems likely since erythrocyte sedimentation is known to be, in part, a function of the plasma proteins.[14]

Summary

In a double-blind study on 84 male dental students, significant alterations of the erythrocyte sedimentation rates were observed in the protein-supplemented (40 grams per day) group after three days. The absence of significant changes in the control (placebo supplement) subjects indicates the possibility that the observed decrease in elevated and increase in low erythrocyte sedimentation rates was mediated by protein supplementation.

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Editorials

SMJAB PRESIDENT RETIRES

Alfred J. Jackson, President and Treasurer of the State Medical Journal Advertising Bureau, Inc., retired effective July 1, 1964. Mr. Jackson came to the American Medical Association on July 23, 1907. He has spent his entire business life in the field of scientific medicine. When the Bureau—then known as the Cooperative Medical Advertising Bureau—was reorganized in December, 1945, Mr. Jackson was appointed Director by the Board of Trustees. In December, 1955, the Bureau was formally separated from the AMA and Mr. Jackson was elected President of the new corporation. Mr. Jackson will continue his service to the State Journal Advertising Group in a consultant capacity.

It has been a pleasure knowing Mr. Jackson for the past few years.

The *Journal* of the Medical Association of the State of Alabama has received much help and many courtesies from him.

This *Journal* wishes Mr. Jackson, good health, happiness, and a pleasant retirement.

PROJECT HOPE

Three Montgomery physicians are participating in the teaching-training hospital ship SS HOPE currently winding up a ten-month medical mission to Guayaquil, Ecuador.

Dr. William A. Daniel, pediatrician, and Dr. H. J. Till, surgeon, will spend two months in the Central American republic where they will teach medical students and interns the "American way of medicine" and treat patients there.

Dr. D. S. Hagood has served on the ship which has been in Ecuador since November. He will return to Montgomery soon.

Twenty physicians and three dentists comprise the fifth and final rotation team that will join the ship's medical staff. The permanent Corps of 84 physicians, nurses, and technical personnel are attached to the HOPE for the duration of a medical mission.

Physicians participating in the two-month project in Ecuador serve with no pay. They

work in the complete hospital on the ship and also work with local doctors.

The project is sponsored by contributions to the "People-to-People Foundation."

The JOURNAL commends these humanitarian physicians.

ALCOHOLISM

At least one in every 21 adults in the United States is alcoholic by medical definition, stated Herbert H. Hill, executive director of Alcohol Problems Association of Seattle, Washington, in an address before the Institute of Scientific Studies for the Prevention of Alcoholism.

Addressing the ninth annual session, Hill, who is associate director of the Institute, told some 50 students that "as you walk down 'Main Street, U. S. A.' every twenty-first adult you meet is alcoholic, statistically speaking."

Hill divided alcoholics into four classifications, of which the first three have normally balanced personalities: (1) Catastrophe Drinkers, who react to some cataclysmic experience; (2) Pressure Drinkers, who have a pre-existent problem; (3) Sensitivity Drinkers, who react to increased pressures of life; and (4) those who have personality deficiencies and who are social misfits.

Pointing out the difference between the "social drinker" and the "reward drinker," Hill said "the 'social drinker' is one who drinks only very small amounts, seldom drinks except on social occasions . . . and tolerates well the mild euphoria and easing of tensions associated with his drinking.

"The 'reward drinker' tends to keep up with, or even a bit ahead of the crowd in his drinking, finds drinking heightens his pleasure at social events, prefers occasions where alcoholic refreshments are served, and enjoys a marked release from tension as a result of drinking," stated Hill.

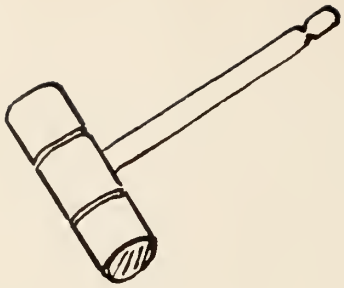
Hill said he became impatient with some of his abstaining friends who feel that drinking is foolish behavior because the individual gets "nothing out of it." "In the case of the 'reward drinker' they are certainly missing the point," remarked Hill. "It is because he is 'getting something out of it' that the 'reward drinker' will keep on drinking—even to the point of self-destruction."

He said the tendency has been to place dramatic values on the transition from social drinking to problem drinking by talking about such symptoms as gulping, hang-overs, and blackouts, when the simple truth is the subtle and meaningful role of alcohol as a "reward" emerges so unobtrusively in the life pattern of the individual as to leave him unaware of its growing importance to him, nor of his own ability to cope with life without it.

"I think too much is made of the 'escape value' of drinking in the life of the problem drinker and the alcoholic, and too little is made of the 'reward potential' of alcohol for the social drinker," stated Hill. "I believe it would be more effective and more understandable to the average social drinker . . . if he were helped to understand that alcoholism does not occur because an individual seeks dramatic 'escape from reality' in drunkenness.

"Rather it is because the nature of alcohol in its effect upon the central nervous system is such as to create illusions of competence, security, and skill, which lead one in the face of insecurity and tension to return unwittingly to the illusion until the capacity for reality is diminished and the appeal of 'escape' is irresistible."

Sponsored by the National Committee for the Prevention of Alcoholism, the Washington Institute began July 27 and was scheduled to conclude August 6.



President's Page



In describing the recent AMA meeting in San Francisco one must think of jet planes for transportation, fabulous sights in a far-away city, medical and national politics at their best (or worst), and of an organization that is streamlined and functions as democratically as any legislative body in this nation can function, the American Medical Association.

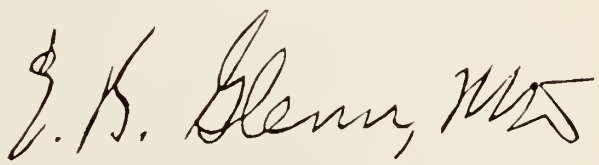
The organization of the AMA is amazing and all state and county groups would do well to follow its example. The House of Delegates is a unicameral body that directs the policy and speaks for the Association. Our own Alabama delegation looks good. The job requires dedication and self-sacrifice as no other position of responsibility does. Close attention to details, attendance and attention in reference committee hearings, buttonholing friends to vote for legislation that is considered proper are a few of the items in a day's work. It goes without saying that the Delegates spend many hours of hard work getting the job done. The hospitality rooms are essential places to carry on the contacts. The Southeastern States entertain at what amounts to a buffet luncheon at noon and a short refreshment hour in the late afternoon. The good will created by Alabama's three delegates when they were hosts this time gave them an entree to any gathering. Dr. Bryce Robinson was elected to the Council on Medical Education last year, the trend being to avoid having all medical

school professors controlling medical education. By keeping eyes and ears to the ground the Alabama group was able to put Bryce in. He has been to all the meetings for a long time and has a lot of friends who supported him. Dr. M. Vaun Adams was chairman of the tellers who counted the votes in the House of Delegates this year, and the election of the President was decided by two votes in favor of Dr. Donovan Ward from Iowa. Behind the scenes, keeping the ball rolling, was John Chenault with his charming and able wife who has been on the Board of the Auxiliary.

The State Presidents have come to the fore in the thinking of the AMA. Many of the State Presidents were attending the meeting for the first time. Forty-seven of the 50 State Presidents were present at the presentation on Sunday afternoon. The occasion was very impressive since it marked the opening of the meeting. The group filed in (led by Alabama, of course) and sat on the rostrum behind the AMA officers and invited guests. Following this the State Society Presidents' meeting was held. Two political candidates were heard, one Republican and one Democrat, from districts in California. Both were conservative in viewpoint. A former president of the Farm Bureau, and Dean Clarence Manion, of Notre Dame Law School, topped the afternoon. Their theme was for anything but the liberal way of thinking.

The State Presidents had lunch as guests of the Board of Trustees prior to the afternoon's activities. They met again on Tuesday at lunch to formulate a program for the State Presidents and Presidents-elect to attend the annual and the clinical meetings of the Association each year. The purpose is to discuss mutual State Association problems rather than the problems of the AMA. Much good can be accomplished by bringing these State officers together. An example in point that was brought out by discussion with the President of the Texas Association was the fact that their delegates are elected for two year terms. Usually they are re-elected unless they are derelict in their duty. One of their men has been serving 13 years.

The Medical Association of the State of Alabama needs to support its delegates to the AMA for all expenses involved; the President and the President-elect should be supported in attending any meeting to which they are invited by the AMA; and if the delegates to the AMA are to be elected, then based on their past performances, they can be re-elected as long as they want the job.



E. B. Glenn, M. D.



ASSOCIATION FORUM

Medical Contributions to Accident Prevention*

PAUL V. JOLIET, M. D.

and

A. L. CHAPMAN, M. D.†

Washington, D. C.

The authors emphasize the physician's role in educating the public to the hazards of accidents and the etiologic factors involved. The importance of this is obvious when one considers the over-all loss of life because of accidents.

For some time the American Medical Association has been active in the field of accident prevention. As a result, state and local medical societies, as well as individual physicians, have become much more aware of the contributions they can make to a reduction in the incidence of accidental deaths and injuries.

There are sound reasons to justify this increased activity.

(1) Accidents cause more deaths than the infectious diseases.

(2) Accidents are the primary cause of death among all age groups from ages one to thirty-six.

(3) National Health Survey reports show that 47 million Americans are injured every year.

(4) In 1910, less than 10% of the youngsters between the ages of 15 and 24 were killed by accidents. This year more than 50% of the deaths in this age group will be due to accidents.

(5) Today, six of every seven man-hours lost in industry result from "off-the-job" accidents.

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*Read before the Section on Preventive Medicine, Southern Medical Association, Fifty-Sixth Annual Meeting, Miami Beach, Fla., Nov. 12-15, 1962.

†From the Division of Accident Prevention, Public Health Service, U. S. Department of Health, Education and Welfare, Washington 25, D. C.

Based on these and other equally revealing statistics, it may be seen that:

(1) Accidents are very costly to workmen and their families.

(2) Accidents reduce the profit of industries.

(3) Accidents place a heavy burden on hospitals and physicians.

(4) Accidents increase taxes because of mounting welfare burdens.

(5) Accidents kill our children with merciless frequency.

(6) Accidents reduce the capacity of the nation to produce goods and provide services so necessary today for national survival.

(7) Accidents erode the efficiency of our armed forces.

Of all the ills that beset us, the accident is the most common and the most insidious—the one about which we know the least.

It is difficult to understand why accidents have not evoked more of a reaction from public health workers and physicians when the health implications of accidents have been so obvious.

It is true that accidents have been thought of as unpreventable events about which nothing could be done. But so were the infectious diseases, once thought of as "scourges" and "pestilences," which, at least in the United States, have been either eliminated or substantially controlled. And it was largely the medical and public health professions that did this.

Each day, more and more people are seeing accidents in their true light—as sequences of events which usually produce unintended injury, death, or property damage.

The elements involved in this sequence of events slowly but surely are being identified, studied, and investigated.

Man, the most important element in the sequence of accident-producing events, can be motivated to live and work, and to drive and play in such a way that he is less likely to have a disabling or fatal accident.

The various environments in which man moves about can be modified in such a way as to minimize the chances of serious accident.

And finally, agents, the instruments of accident causation, can be "delethalized"—can be constructed—in such a way that they can be used with less chance of personal injury and death.

When accidents are looked at from this epidemiologic point of view, it becomes obvious that physicians can contribute much to their control.

(1) *Physicians can educate.*

They can educate parents about the dangers of child poisoning.

They can advise oldsters not to drive cars when they are physically unfit to do so (strokes).

They can protect patients under medication from unnecessarily exposing themselves to accident-causing situations (diabetes).

(2) *Physicians can set an example.*

They can install and use seat belts in their cars and advise their patients to use them.

They can wear life vests when boating.

They can obey local driving laws and ordinances.

They can develop escape plans for their family in case of fire.

They can obey prescribed safety practices while hunting.

(3) *Physicians can assist others in the community to make the community safer.*

They can help teach ambulance crews how to properly handle the injured.

They can teach mouth-to-mouth breathing to community groups.

They can help organize community resources to insure the teaching of youngsters to swim.

They can help develop poison control centers or improve their operation.

(4) *Physicians can become safety leaders in their community.*

They can participate in the activities of the local safety council, if one exists, or help establish one if one is needed.

They can encourage and cooperate with local health departments in doing the many things that can be done to make safe living a reality.

The list of specific activities that can be engaged in by physicians willing to serve their community better is very long.

For further specifics, I would like to refer you to a book entitled "Accident Prevention—The Role of Physicians and Public Health Workers," published by McGraw-Hill Book Company for the American Public Health Association. Of particular interest to physicians would be:

The Introduction—by Dr. F. J. L. Blasingame, Executive Vice-President of the American Medical Association.

Chapter 16—The Physician's Role by Dr. Carl Potthoff.

Chapter 18—Programs for Physicians and Medical Societies by Dr. William W. Bolton of the American Medical Association.

Chapter 11—Medical Aspects of Industrial Fleet Driving by Dr. Harold Brandeleone.

It has been stated that the majority of accidents are precipitated primarily by human factors. These are factors within individuals which reflect their physical, emotional, and physiologic condition. That is what makes the study of accident prevention so difficult.

A farmer, performing essentially the same chores he has performed for 20 years, one day has his hand caught in a corn picker.

Why?

A review of the accident situation may reveal no change in the environment, and no defect in the corn picker.

However, there may have been—in fact, there must have been some change in the farmer.

Was it in his physical condition? Had age finally slowed his reflexes so an act he had done repeatedly without injury over a period of many years was no longer safe?

Was his vision at fault?

Or, was he suffering from diabetes, a cold, or some other undiagnosed or untreated infirmity?

Or was it his physiologic function that was at fault?

Perhaps a "nip" or two at lunch time?

Or antihistamine pills because of his hay fever?

Or was he just tired out from the school-board meeting he attended the night before?

Perhaps there really was nothing wrong with him physically. The trouble might all "have been in his head." Was he thinking too seriously about a recent crop loss? Perhaps he was preoccupied about the condition of his wife whose gall bladder had to come out? Maybe it was worry over the cost of repairing his car—a motor overhaul costs a lot of money these days.

This make-believe story was told to give you some idea of the scope and complexity of the problem which faces research workers who at long last are seriously attacking the problem of accident prevention.

On the other hand, this story was not intended to convey to you the idea that nothing can be done to solve this complex problem until a lot more research has been completed.

An intelligent beginning can be made by analyzing the problem—by breaking it down into manageable parts.

Once a man was asked if he could swallow an elephant, his reply was most astute. "I can if I can cut the elephant up and eat it one piece at a time."

So, what are some of the more important parts of the accident elephant?

At least seven can be identified and worked upon as special problems. Accidents in or by a motor vehicle quantitatively and emotionally are of prime importance. Then come

falls, drowning, other transport accidents, fires and explosions, poisoning, and firearms.

Already the problem seems less complex.

Time does not permit describing all of the technics of accident prevention of proven value under each heading, but let me list just a few examples under each:

Motor vehicles—seat belts, driver education, implied consent laws.

Falls—better supervision of children and old people.

Drowning—swimming instruction, and mouth-to-mouth resuscitation.

Fires—family escape plan, fireproof fabrics and paints.

Poisoning—put medicines out of reach of children, store household cleaning materials in a safe place.

Firearms—courses in gun safety, safe storage of guns at home.

Finally, let us talk a moment about attitudes.

In the long run, is it the individual's attitude more than anything else which determines whether or not he will exceed his capacities and run the risk of having an accident?

A reporter for *World Health,* in preparing an issue on accident prevention, saw fit to interview a mountaineer, a racing motorcyclist, a racing motorist, and a woman acrobat-parachutist—all risk takers.

When asked about his attitude towards accidents, the mountain climber said, *"It is much more difficult to give up than to go on."*

Does not this attitude apply to the driver who has driven too many miles, to the farmer who has worked too many hours, to the doctor who has made too many calls?

The motorcycling champion said, *"Calculate every move you make."*

Is not that equally applicable to all of us? To the young man driving a car, to the old man walking downstairs, to the veterinarian handling an animal that may be rabid?

The automobile racing champion said, *"Any kind of physical or mental weakness will inevitably tell."*

His life depends on his own awareness of this simple fact. How many of us recognize the same basic truth as it applies to our own safety—while living our own much more prosaic lives?

Again—an attitude if you will.

Finally, the woman who does aerial acrobatics and parachute drops said very pungently, *"I refuse to take risks that involve pure chance."* I think that is a real pearl of wisdom in accident prevention.

In other words, like all of us, she must take risks to earn a living—even to live a normal life, but she never trusts her life to pure chance. She observes precautions; she keeps in good physical and mental condition; and she evaluates the nature of the risk she is taking.

On this note I will conclude.

Accidents are one of the greatest threats to life and limb today.

Accidents are the result of a complex interaction between man and his environment that must be made the subject of a much more intensive research effort.

However, there are many things that can be done today to educate, to develop proper attitudes, to modify the environment, and that can significantly reduce today's great accident toll.

Human factors are of great importance in accident causation.

Physicians can save many lives and prevent many disabilities by lending a hand in accident prevention.

I am confident they will.

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around the state







Candid Camera at meeting of the Committee on Aging and the Indigent, July 1, 1964, at the Association Building, Montgomery, Alabama.

MEDICAL PROGRESS ASSEMBLY

A speaking faculty of 45 distinguished physicians will present latest developments in a broad range of medical subjects at the Seventh Annual Medical Progress Assembly in Birmingham, September 13-15.

The Assembly, one of the South's fastest-growing postgraduate medical educational meetings, will be held at the new Parliament House Motor Hotel. It is approved for 14 hours of Category I credit by the American Academy of General Practice.

Special entertainment events have been planned for both physicians and their wives. The program will open with a reception and buffet at the Parliament House featuring Coach Paul "Bear" Bryant as after-dinner speaker Sunday evening.

Indicative of the renown of this year's program speakers are: Dr. Thomas P. Almy, Cornell University Medical College, New York—"Pathogenesis and Management of Malabsorptive Syndromes"; Dr. Arnold P. Friedman, Montefiore Hospital, Headache Unit, New York—"Headache"; Dr. Loyal Davis, neurosurgeon, Northwestern, Chicago —"Changing Concepts of Strokes"; Dr. Harry Seneca, Presbyterian Hospital, New York— "Latest Studies Concerning the Treatment of Chronic Drug Resistant Infections and the Relationship between the Normal Intestinal Flora and Kidney Stones and Infection"; Dr. Robert B. Wilson, Mayo Clinic, Rochester, Minnesota—"Third Stage of Labor"; Dr. Harwell Wilson, University of Tennessee, Memphis, Tennessee—"The Acute Abdomen"; Dr. John W. Hillman, Vanderbilt University, Nashville, Tennessee—"Fat Embolism"; Dr. Stuart C. Cullen, University of California, San Francisco, California—"The Role of Monitors in Anesthetic Practice"; Dr. Clifford C. Snyder, University of Miami, Miami, Florida—"Snakebite"; Dr. Lewis C. Mills, Hahnemann Medical College and Hospital, Philadelphia, Pennsylvania—"Newer Concepts in the Pathogenesis and Treatment of Shock"; Dr. John B. Bryan, Henry Ford Hospital, Detroit, Michigan—"Use of Agents that Influence Aldosterone in the Management of Edema States"; Dr. John J. Shea, otolaryngologist, Memphis, Tennessee—"The Teflon Piston Operation for Otosclerosis"; Dr. Harris D. Riley, University of Oklahoma, Oklahoma City, Oklahoma—"Recent Advances in Antibiotic Therapy"; Dr. Raymond Osbourn, Georgetown University, Washington, D. C.— "The Management of Some Common Problems in Pediatric Dermatology"; Dr. Roy Parker, Duke University, Durham, North Carolina—"Pruritus Vulvae"; Dr. Ian M. Thompson, University of Missouri, Columbia, Missouri—"Pitfalls in the Management of Abdominal Masses in Children."

The state's physicians are also invited to pre-assembly seminars sponsored by the Alabama Diabetes Association (Sunday, September 13) and the Alabama Obstetrical and Gynecological Society in conjunction with the Birmingham Obstetrical and Gynecological Society (Saturday, September 12).

Social activities will include a dinner and dance at Vestavia Country Club, Monday evening, and a luncheon and fashion show for the doctors' wives. Door prizes will be awarded and refreshments will be served during breaks for viewing the technical exhibits.

OBITUARIES

BEDSOLE—Dr. James Goodman Bedsole a general practitioner in Jackson, Alabama died on September 15, 1963 at the age of 76.

Dr. Bedsole received his M. D. degree from Vanderbilt University in Nashville, Tennessee. He was graduated with highest honors.

He served in the United States Army during World War I.

Citizens of Jackson, Alabama honored Dr. Bedsole with a "Dr. J. G. Bedsole Day" when he had practiced there for 35 years.

Dr. Bedsole was a member of the Clarke County Medical Society, the Medical Association of the State of Alabama, and the American Medical Association. He was a Life Counsellor of the State Medical Association. He was on the staff of the Mobile Infirmary and Jackson Hospital. He was the chairman of Jackson Hospital Staff when it was organized. He was a member of the Methodist Church.

Dr. Bedsole is survived by his wife, Mrs. Bertha G. Bedsole; a son, James G. Bedsole, Jr.; a daughter, Mrs. Martha Bedsole Goodloe; and six grandchildren.

CLEVELAND—Dr. Claude Mastin Cleveland, Sr., an anesthesiologist of Mobile, Alabama died on June 16, 1964 at the age of 69. He was a native and lifelong resident of Mobile.

Dr. Cleveland received his M. D. degree from Tulane University in New Orleans, Louisiana in 1921. He was a member of the Medical Society of Mobile County and the Medical Association of the State of Alabama. He was retired at the time of his death.

He is survived by his wife, Mrs. Elizabeth Hudson Cleveland, two daughters, Mrs. JoAnne Cleveland Ladner, Mobile; Mrs. Nan Cleveland Netherland, New Orleans, Louisiana; two sons, C. M. Cleveland, Jr., and Paul McGehee Cleveland, both of Mobile; and five grandchildren.

DAVIDSON—Dr. James Samuel Davidson, Jr., Clarke County Health Officer died on April 16, 1964 at the age of 60.

Dr. Davidson received his B. S. degree from Spring Hill College in Mobile, Alabama and his M. D. degree from Tulane University, New Orleans, Louisiana. He served his internship at Charity Hospital in New Orleans.

He was a member of the Clarke County Medical Society and the Medical Association of the State of Alabama.

Dr. Davidson is survived by his wife Edna; four sons, James S. Davidson, III, William R. Davidson, Edward W. Davidson, and J. Patrick Davidson; two daughters, Mrs. Lamar Boone, Jr., and Mrs. Gene Davis; and five grandchildren.

GRAY—Dr. Henry Warren Gray, a general practitioner of Mobile, Alabama was born August 8, 1873 in Waynesboro, Mississippi and died July 7, 1964 in Mobile, Alabama.

Dr. Gray was graduated from Louisville Medical College in Louisville, Kentucky in 1903.

He started his practice in Chicora, Mississippi and later moved to Meridian. He moved to Mobile, Alabama in 1912. Dr. Gray won distinction during the influenza epidemic in 1918. He did not lose a patient.

He was a member of the Medical Society of Mobile County, the Medical Association of the State of Alabama, and the American Medical Association.

Dr. Gray retired in 1962.

He is survived by his son, Eugene H. Gray, Mobile; five sisters, Mrs. Berta Huggins, Mrs. Alice West, Mrs. Mamie Russell and Mrs. Sally Gillis, all of Waynesboro, Mississippi, and Mrs. Bessie Dearman of Meridian, Mississippi; and two brothers, Dr. A. H. Gray of Kenton, Tennessee, and C. M. Gray of Vicksburg, Mississippi.

McBURNEY—Dr. Ralph McBurney, a former professor in the University of Alabama School of Medicine and Tuscaloosa County Health Officer from 1955 to 1961, died June 21, 1964 at the Veterans Administration Hospital in Tuscaloosa, Alabama at the age of 80.

Dr. McBurney was born August 9, 1883 in Alexandria, Virginia. He received his B.S. degree in chemistry from Virginia Polytechnic Institute in 1908 and his M.S. degree in 1916 from Oklahoma Agricultural and Mechanical College. He began his career as a chemist for General Chemical Company of Baltimore in 1909 and served as an instructor in chemistry at Oklahoma A & M from 1910 until 1914.

From 1914 until 1917 he served as an instructor in bacteriology at Oregon State College. He served as assistant professor of bacteriology at the University of Missouri and assistant director of the Missouri State Health Laboratory from 1919 until 1921.

Dr. McBurney joined the staff of the University of Alabama in 1921 as an associate professor of bacteriology the second year after it moved to Tuscaloosa. While teaching at the University he was a student from 1925 until 1927.

In 1928 Dr. McBurney was named professor and head of the University of Alabama department of bacteriology and clinical pathology.

He received his M. D. degree in 1929 from Rush Medical College, University of Chicago, and interned at the TCI Hospital in Fairfield. He then received his master of public health degree in 1931 from Harvard University.

Dr. McBurney retired from the University of Alabama Medical School staff in 1954.

He was a member of the Tuscaloosa County Medical Society, the Medical Association of the State of Alabama, the Society of American Bacteriologists, the Society of Experimental Biology and Medicine, the Alabama Academy of Science, and the American Medical Association. He was a past president of the Medical Alumni Association of Alabama.

Dr. McBurney served as collaborator of Kracke's Textbook of Clinical Pathology, 1st and 2nd editions, and Textbook of Clinical Pathology, 4th and 5th editions. He was author of a laboratory manual of bacteriology and serology and had contributed articles to numerous scientific and medical journals.

Dr. McBurney was listed in Who's Who in America.

Survivors include his wife; three sons, George McBurney of Florence, Dr. Robert McBurney of Memphis, Tennessee, and Charles McBurney of Sarasota, Florida; and seven grandchildren.

MEIGS—Dr. James Hurst Meigs, one of Alabama's leading general practitioners, died on May 21, 1964 in Anniston, Alabama, at the age of 63.

Dr. Meigs was born in Albertville, Alabama. His father was a newspaper publisher of that city, and his mother, the late Mrs. Mary Meigs, was for many years principal of the Woodstock School.

Following his schooling in Albertville, Dr. Meigs went to Birmingham-Southern College, the University of Alabama Medical School, and was graduated from Vanderbilt University Medical School in 1925.

He interned at Norwood Hospital in Birmingham, and his residency was at New York Memorial Hospital. He returned to Alabama and started private practice at Cordova. He later moved to Bradford, and from there to Anniston in 1934.

Dr. Meigs continued his practice in Anniston, except for three years service in the Air Force where he was flight surgeon in the 313th Combat Wing. After a year in the Pacific Theater he was discharged with the rank of Major.

Among his civic activities during his 30 years of service in Anniston were: Boy Scout Council; charter member of the YMCA Board; chief of staff, Anniston Memorial Hospital; chief of staff, Stringfellow Memorial Hospital; director of the Anniston Chamber of Commerce; and member of the Third Army Advisory Committee, American Legion.

He was a deacon of the First Presbyterian Church.

Dr. Meigs was past president of the Calhoun County Medical Society, vice-president of the Medical Association of the State of Alabama, member of the American Medical Association, and the Alabama Chapter of the American Academy of General Practice.

Dr. Meigs is survived by his wife, Mrs. Helen Meigs; one son, James H. Meigs, Jr., of Anniston; one daughter, Mrs. Herbert H. Hill of El Campo, Texas; and four grandsons, Paul Herbert Hill, Jon Meigs Hill, James H. Meigs, III, and William Acker Meigs.

Dr. James Hurst Meigs will be long remembered for his integrity and his devotion to the medical profession.

WILLIAMS—Dr. Keller Bell Williams, a general practitioner in Hartford, Alabama, died on July 10 at the age of 87.

Dr. Williams was a native of Coosa County, Rockford, Alabama.

He attended the University of the South, Sewanee, Tennessee where he graduated from medical school in 1907. He did postgraduate work at Tulane University, New Orleans, Louisiana.

Dr. Williams was a member of the First Methodist Church in Hartford. He was a member of the Geneva County Medical Society, the Medical Association of the State of Alabama, and the American Medical Association.

A certificate of distinction was presented to Dr. Williams in 1958 commemorating 50 years of service to the medical profession.

Dr. Williams is survived by two sons, Keller B. Williams, Hartford, Alabama, and Dr. Thomas Frasier Williams, Arlington, Virginia; two daughters, Mrs. Lois W. Carroll, Mobile, Alabama, and Mrs. Mellijo McKinnon, Pensacola, Florida; two brothers, Mack Williams, Jacksonville, Florida, and Houston Williams, Goodwater, Alabama; three sisters, Mrs. Ben Beard, Mrs. Cora Bush, and Mrs. Robbie Williams, Birmingham, Alabama; five grandchildren; and four great-grandchildren.

BUREAU OF LABORATORIES

Thomas S. Hosty, Ph.D., Director

June 1964

Examinations for intestinal parasites	1,023
Typhoid cultures (blood, feces, urine and other)	305
Brucella cultures	1
Examinations for malaria	9
Examinations for gonococci	1,767
Serologic tests for syphilis (blood and spinal fluid)	25,733
Darkfield examinations	5
Examinations for diphtheria bacilli and Vincent's	13
Complement fixation tests	62
Examinations for Negri bodies (smears and animal inoculations)	288
Water examinations	2,950
Milk and dairy products examinations	3,634
Examinations for tubercle bacilli	3,808
Miscellaneous examinations	3,957
Total	43,555

* * *

BUREAU OF PREVENTABLE DISEASES

W. H. Y. Smith, M. D., Director

CURRENT MORBIDITY STATISTICS

1964

	May	June	*E. E. June
Tuberculosis	177	120	161
Syphilis	135	118	154
Gonorrhea	361	270	310
Chancroid	6	0	4
Typhoid fever	1	2	1
Undulant fever	0	0	1
Amebic dysentery	5	1	3
Scarlet fever & strep. throat	42	77	39
Diphtheria	0	0	1
Whooping cough	62	68	34
Meningitis	9	12	5
Tularemia	0	0	0
Tetanus	1	0	3
Poliomyelitis	2	0	1
Encephalitis	0	0	1
Smallpox	0	0	0
Measles	15,229	1,981	354
Chickenpox	729	73	46
Mumps	590	54	28
Infectious hepatitis	44	29	27
Typhus fever	0	1	1
Malaria	0	0	0
Cancer	928	1,018	529
Pellagra	5	2	0
Rheumatic fever	34	17	9
Rheumatic heart	26	27	20
Influenza	90	10	45
Pneumonia	297	226	164
Rabies—Human cases	0	0	0
Pos. animal heads	3	1	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

BUREAU OF VITAL STATISTICS

Ralph W. Roberts, M. S., Director

PROVISIONAL BIRTH AND DEATH STATISTICS FOR MAY, 1964, AND COMPARATIVE DATA

Live Births / Deaths / Causes of Death	Number Registered During May, 1964			Rates* (Annual Basis)		
	Total	White	Non-White	1964	1963	1962
Live Births	5,618	3,647	1,971	19.5	18.8	21.4
Deaths	2,616	1,715	901	9.1	8.7	9.0
Fetal Deaths	125	52	73	21.8	21.8	22.9
Infant Deaths—						
under one month	120	66	54	21.4	23.6	21.7
under one year	168	88	80	29.9	31.8	30.8
Maternal Deaths	5	4	1	8.7	9.1	8.0
Causes of Death						
Tuberculosis, 001-019	18	13	5	6.2	8.4	6.3
Syphilis, 020-029	3	3		1.0	1.4	0.4
Dysentery, 045-048	1		1	0.3	0.3	
Diphtheria, 055						
Whooping cough, 056	1		1	0.3		
Meningococcal infections, 057	2	1	1	0.7		0.7
Poliomyelitis, 080, 081					0.3	
Measles, 085	2	1	1	0.7	0.3	0.4
Malignant neoplasms, 140-205	339	250	89	117.5	123.3	118.1
Diabetes mellitus, 260	50	28	22	17.3	11.9	14.5
Pellagra, 281					0.3	0.7
Vascular lesions of central nervous system, 330-334	336	204	132	116.5	122.9	128.0
Rheumatic fever, 400-402	2	1	1	0.7	0.7	
Diseases of the heart, 410-443	906	632	274	314.1	299.6	310.0
Hypertension with heart disease, 440-443	130	47	83	45.1	40.9	53.2
Diseases of the arteries, 450-456	65	47	18	22.5	18.9	27.9
Influenza, 480-483	4	3	1	1.4	2.8	2.5
Pneumonia, all forms, 490-493	60	32	28	20.8	17.1	22.2
Bronchitis, 500-502	6	5	1	2.1	1.4	1.8
Appendicitis, 550-553	1		1	0.3	0.7	0.4
Intestinal obstruction and hernia, 560, 561, 570	11	8	3	3.8	4.5	6.3
Gastro-enteritis and colitis, under 2, 571.0, 764	3	1	2	1.0	1.4	2.5
Cirrhosis of liver, 581	14	11	3	4.8	3.1	8.1
Diseases of pregnancy and childbirth, 640-689	5	4	1	8.7	9.1	8.0
Congenital malformations, 750-759	42	31	11	7.5	4.8	3.5
Immaturity at birth, 774-776	39	20	19	6.9	8.0	6.4
Accidents, total, 800-962	203	149	54	70.4	58.7	59.6
Motor vehicle accidents, 810-835, 960	98	72	26	34.0	26.9	25.4
All other defined causes	352	212	140	122.0	126.8	130.8
Ill-defined and unknown causes, 780-793, 795	150	58	92	52.0	43.0	31.4

*Rates: Birth and death—per 1,000 population
Infant deaths—per 1,000 live births
Fetal deaths—per 1,000 deliveries
Maternal deaths—per 10,000 deliveries
Deaths from specified causes—per 100,000 population

The Woman's Auxiliary



Dear Doctors:

It is a cloudy day out here on Smith Lake. We've had lunch and the children are resting, getting ready to keep me busy with an afternoon of swimming and skiing. If we lived in California, they could surf and no one would have to run the boat, but Alabama's green looks a lot better than California's unirrigated brown.

I wish all of you could have been at the Auxiliary's meeting in San Francisco when the state reports were given. You would have been proud of your wives. Each state was supposed to report on an outstanding project. Alabama used the Sabin immunization drive that was put on in so many of our counties. Washington, D. C. bragged about feeding 11,500 in a shopping center parking lot, but Jefferson County wives fed 14,000 at the stadium. Aren't you Jefferson County husbands proud of your wives and Eloise Crenshaw, last year's Jefferson-Birmingham president and this year's president-elect of the State Auxiliary?

It was that way with report after report. Your wives had done as much or more on project after project. Health Career Recruitment so you will have well-trained help in your hospitals and offices, Gems baby sitter courses as part of the safety program. I do hope we can have some Accident Prevention Schools for mom's and dad's and Poison Safety Programs on the county level to help protect our young citizens.

Growth in membership was the only place we didn't keep up with some of the rest of the states. Of course they didn't quite play fair, the men paid their wives dues with their County Society dues. That makes the wife belong even if she doesn't want to, or if her husband doesn't favor Auxiliary membership. Most of us are against this, we believe in freedom of choice, we want you to want your wife to belong and we want her to want to belong because she likes Auxiliary work and because you think we are doing a worthwhile job for you. We want workers, not members.

Our AMA-ERF record, while not prize-winning, was very good. The Dean of the Medical School, Dr. S. Richardson Hill, made me very happy when he wrote asking for Mrs. William H. Anderson's name, the new AMA-ERF Chairman, so he could write her and tell her how much the Medical School appreciates our efforts to support medical education.

Do you want to know what would make me happy? Why don't you write me or ask your wife to ask her county Auxiliary to do a project you think is necessary and would help you, your community, and the State of Alabama.

Eloise would have something to brag about in New York. A job requested by you to meet a local need. We would know we were pleasing you which is our greatest desire.

Write.

Sincerely,

Frances B. Clemmons

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Early investigations showed that Pro-Banthīne (propantheline bromide) reduces motility and acid secretion and may be used in a wide range of dosage, to bring prompt, positive anticholinergic benefits to patients with peptic ulcer, spastic colon, pylorospasm and related gastrointestinal dysfunctions.

Recent evaluations sustain these earlier judgments. In a current authoritative assessment based mainly on the factors of potency, superiority to atropine, clinical experience and physiologic study, Steinberg and Almy[2] select as the first two preferred anticholinergic drugs, methantheline [Banthīne] and propantheline [Pro-Banthīne].

The name Pro-Banthīne (propantheline bromide) sets a stamp of therapeutic authority on any anticholinergic prescription.

Side Effects and Precautions—Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur. The drug is contraindicated in patients with glaucoma or severe cardiac disease.

Dosage—The usual adult dosage is one tablet of 15 mg. with meals and two at bedtime; this amount may be doubled or tripled for patients with severe conditions. Pro-Banthīne (brand of propantheline bromide) is supplied as tablets of 15 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

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Research in the Service of Medicine

1. Roach, T. C.: Therapy of Peptic Ulcer, J. Louisiana Med. Soc. *115*:136-139 (April) 1963.
2. Steinberg, H., and Almy, T. P., Drugs for Gastrointestinal Disturbances, Chapter 21, in Modell, W. (editor): Drugs of Choice —1964-1965, St. Louis, The C. V. Mosby Company, 1964, p. 343.

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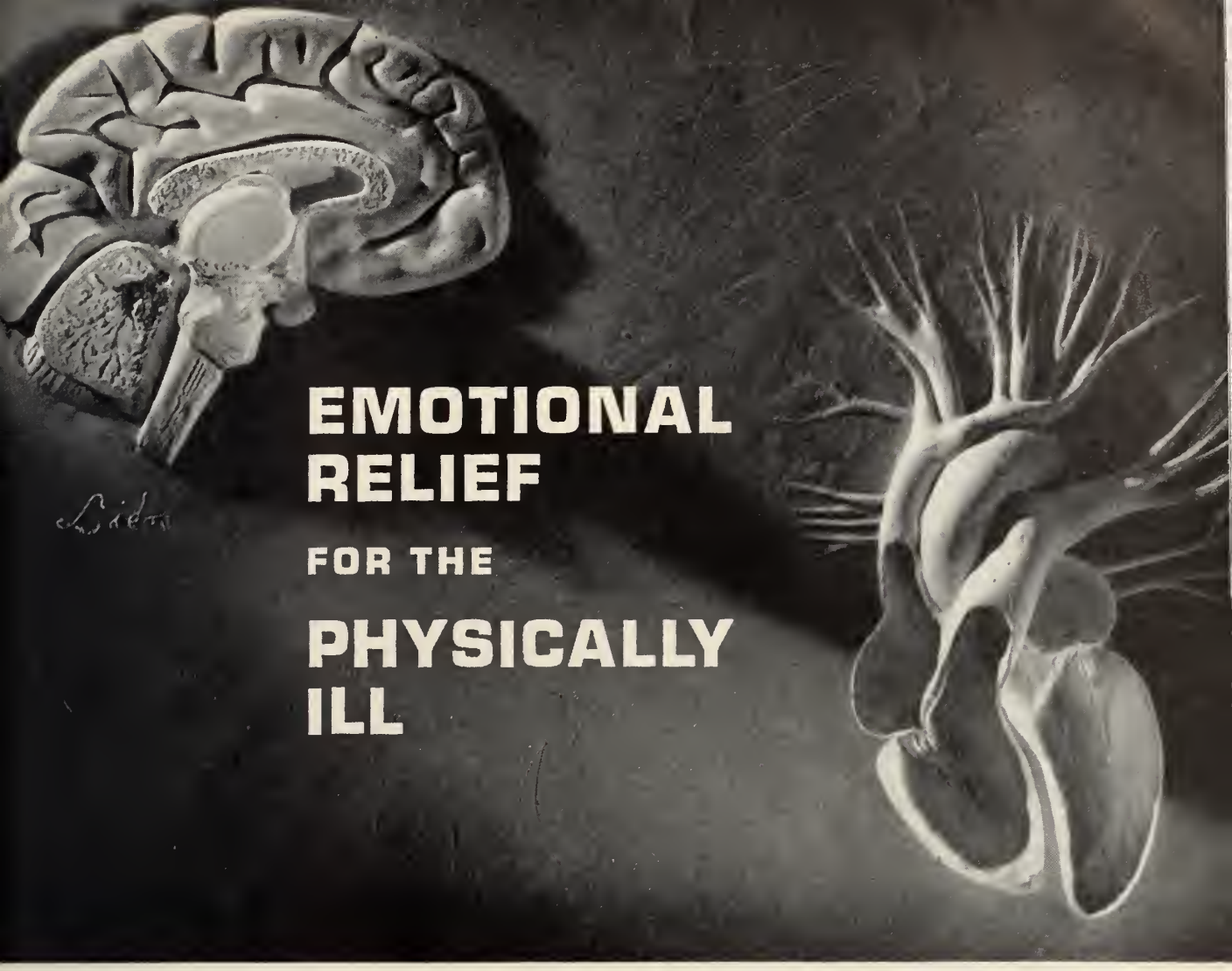
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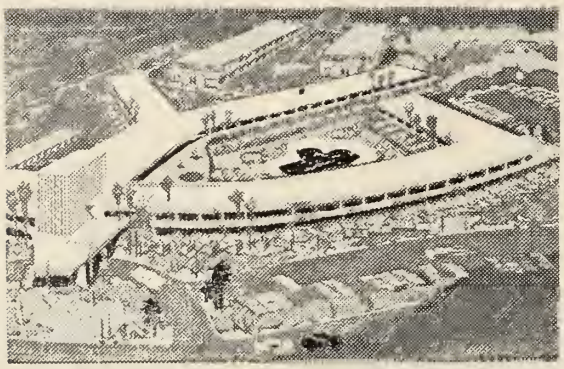
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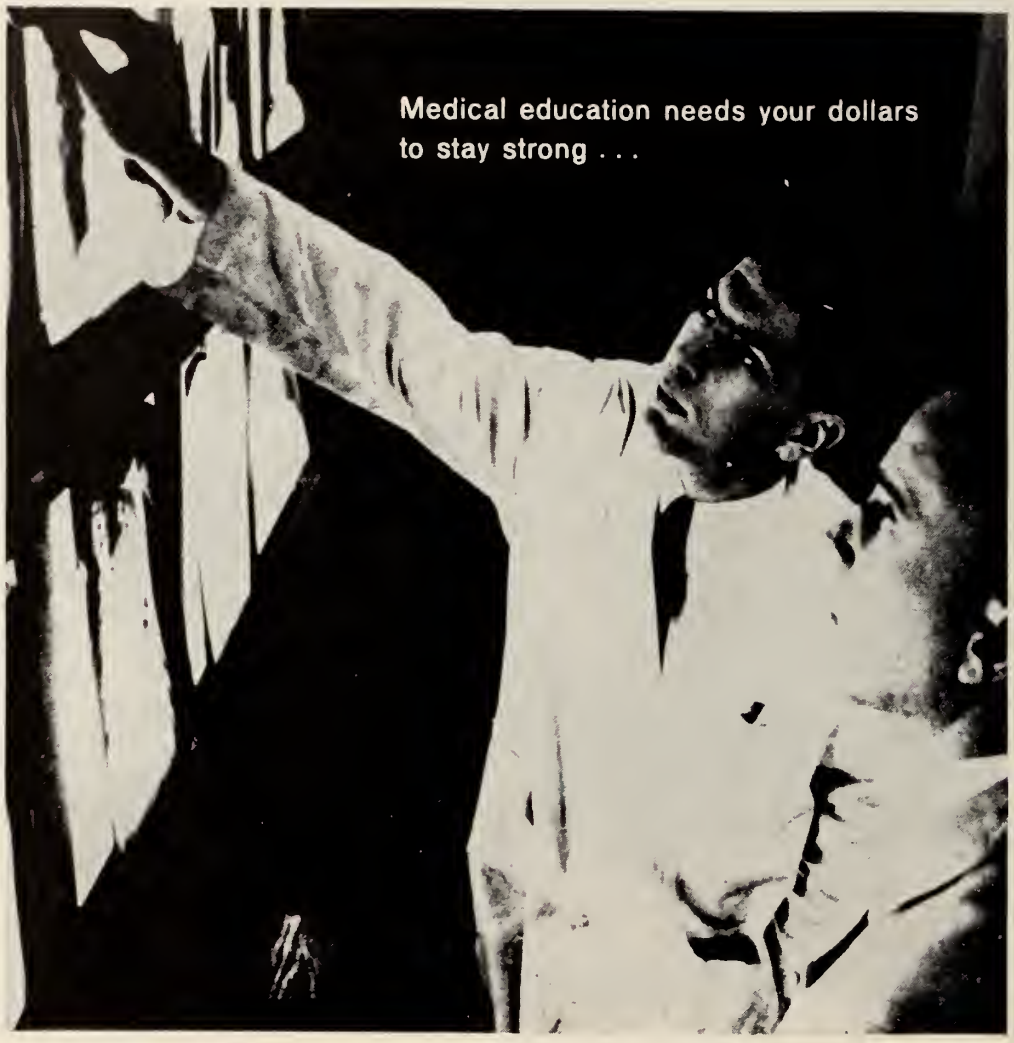
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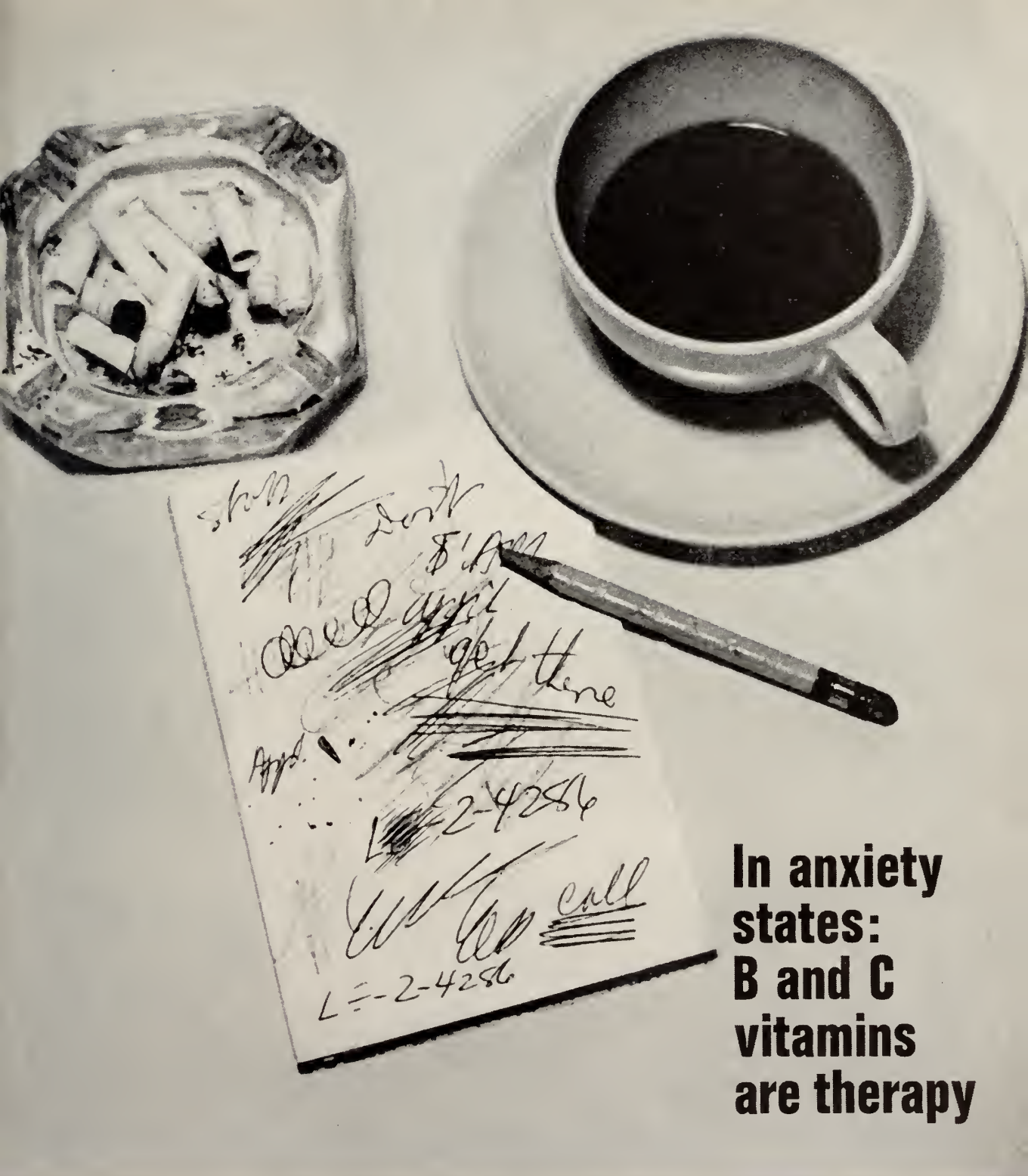
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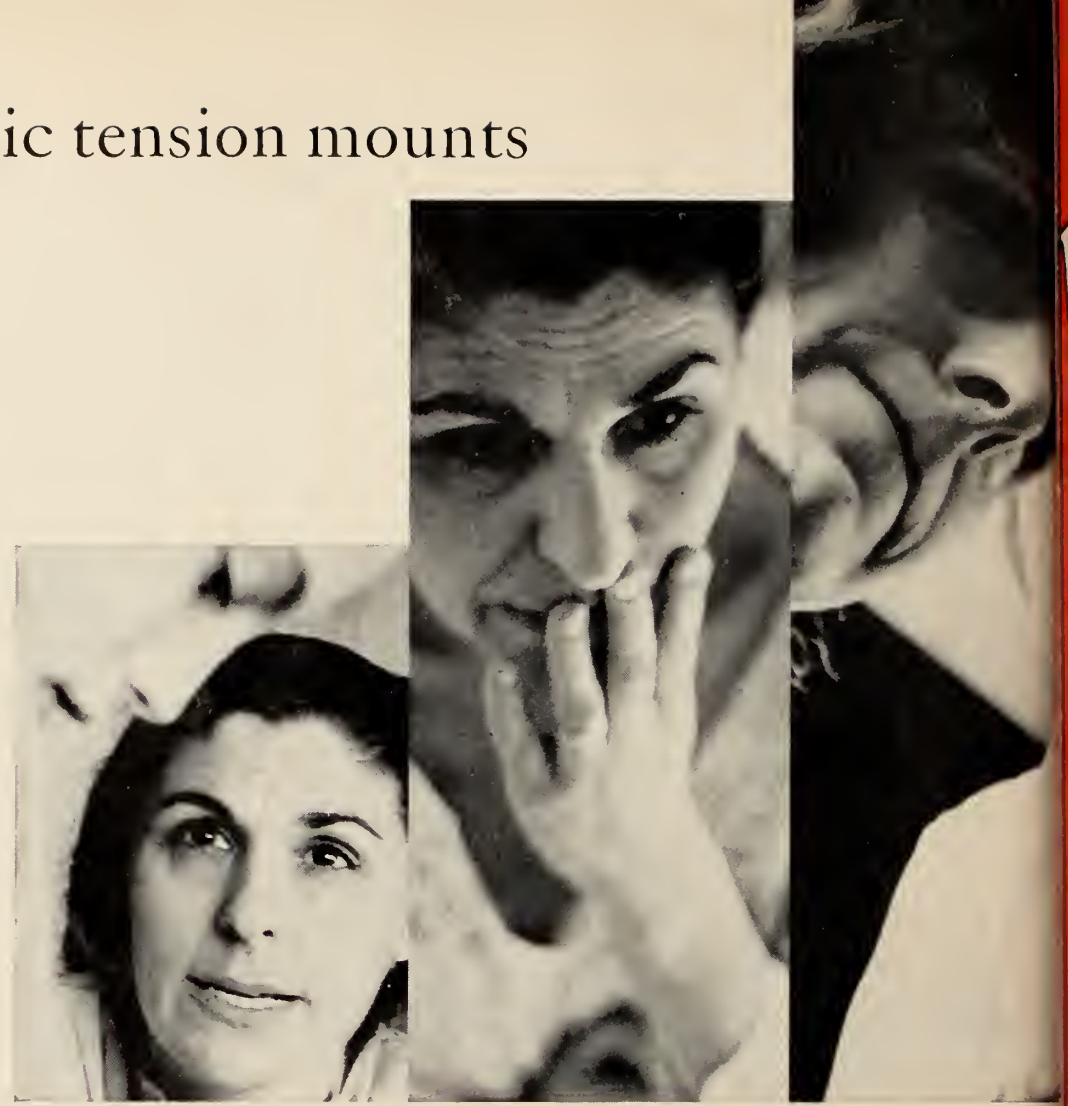
Average adult dose: 1, or if needed, 2 tablets three times daily. *Precautions:* Observe patients periodically for increased intraocular pressure and barbiturate habituation or addiction. Caution drivers against possible drowsiness. *Side effects:* Dehydrocholic acid may cause transitory diarrhea; belladonna — blurred vision, dry mouth. *Contraindications:* Biliary tract obstruction, acute hepatitis, glaucoma, and prostatic hyperplasia. *Available through your regular supplier:* DECHOLIN-BB, bottles of 100 tablets. 72664

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How to prescribe Valium (diazepam)

Indications: Valium (diazepam) is of use in dealing with anxiety reactions stemming from stressful circumstances or whenever somatic complaints are concomitants of emotional factors. It is useful in psychoneurotic states manifested by anxiety, tension, fear and fatigue. Valium (diazepam) may also be useful in acute agitation due to alcohol withdrawal. Valium (diazepam) may be of use to alleviate muscle spasm associated with cerebral palsy and athetosis.

Dosage and administration	*Usual daily dose*
Mild to moderate psychoneurotic reactions: Manifested by anxiety-tension alone or with depressive symptomatology, agitation, restlessness, psychophysiological disturbances	2 mg to 5 mg, 2 or 3 times daily
Severe psychoneurotic reactions: Where severe anxiety, fear, agitation, aggression or hostility exist alone or with depressive symptoms	5 mg to 10 mg, 3 or 4 times daily
Alcoholism: As an aid in symptomatic relief of acute agitation, tremor, impending or acute delirium tremens and hallucinosis	10 mg, 3 or 4 times during the first 24 hours; reducing to 5 mg, 3 or 4 times daily as needed
Muscle spasm associated with cerebral palsy or athetosis	2 mg to 10 mg, 3 or 4 times daily

Contraindications: Valium (diazepam) is contraindicated in infants, patients with a history of convulsive disorders or patients with a history of glaucoma.

Warning: Valium (diazepam) is not of value in dealing with psychotic patients manifesting anxiety and should be avoided when there is reason to believe the patient is psychotic.

Precautions: In elderly or debilitated patients, it is important to limit the dosage to the smallest effective amount to preclude the development of ataxia or oversedation (not more than 1 mg, 1 or 2 times daily initially, to be increased gradually as needed and tolerated). As is true of all CNS-acting drugs, until the correct maintenance dosage is established, patients receiving Valium (diazepam) should be advised against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving automobile during the period of Valium (diazepam) therapy is not recommended. In general, the concurrent administration of Valium (diazepam) and other psychotropic agents is not recommended. If such combination therapy is used, careful consideration should be given to the pharmacology of the agents to be employed with Valium (diazepam) — particularly with known compounds which may potentiate the action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants.

Since Valium (diazepam) has a central nervous system depressant effect, patients should be advised against the simultaneous ingestion of alcohol and other central nervous system depressant drugs during Valium (diazepam) therapy. Safe use of Valium (diazepam) during pregnancy has not been established. The usual precautions are indicated when Valium (diazepam) is used in the treatment of anxiety states where there is any evidence of impending depression; particularly the recognition that suicidal tendencies may be present and protective measures may be necessary. The usual precautions in treating patients with impaired renal or hepatic function should be observed.

Side effects: In clinical use, fatigue, drowsiness and ataxia have been reported; in most instances these are dose-related and may be avoided by proper dosage adjustment. Mild nausea and dizziness may occur on occasion. As with any new agent, when it is administered for protracted periods of time, periodic blood counts and liver function tests are advisable. Abrupt cessation after prolonged overdosage may, in some patients, produce withdrawal symptoms (*e.g.*, convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and Librium® (chlordiazepoxide HCl). Changes in EEG patterns have been observed in patients during and after Valium (diazepam) treatment.

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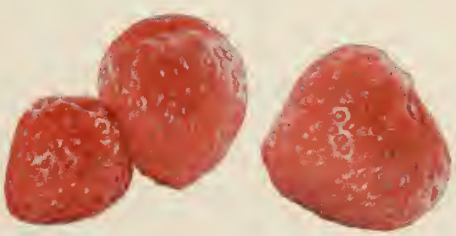
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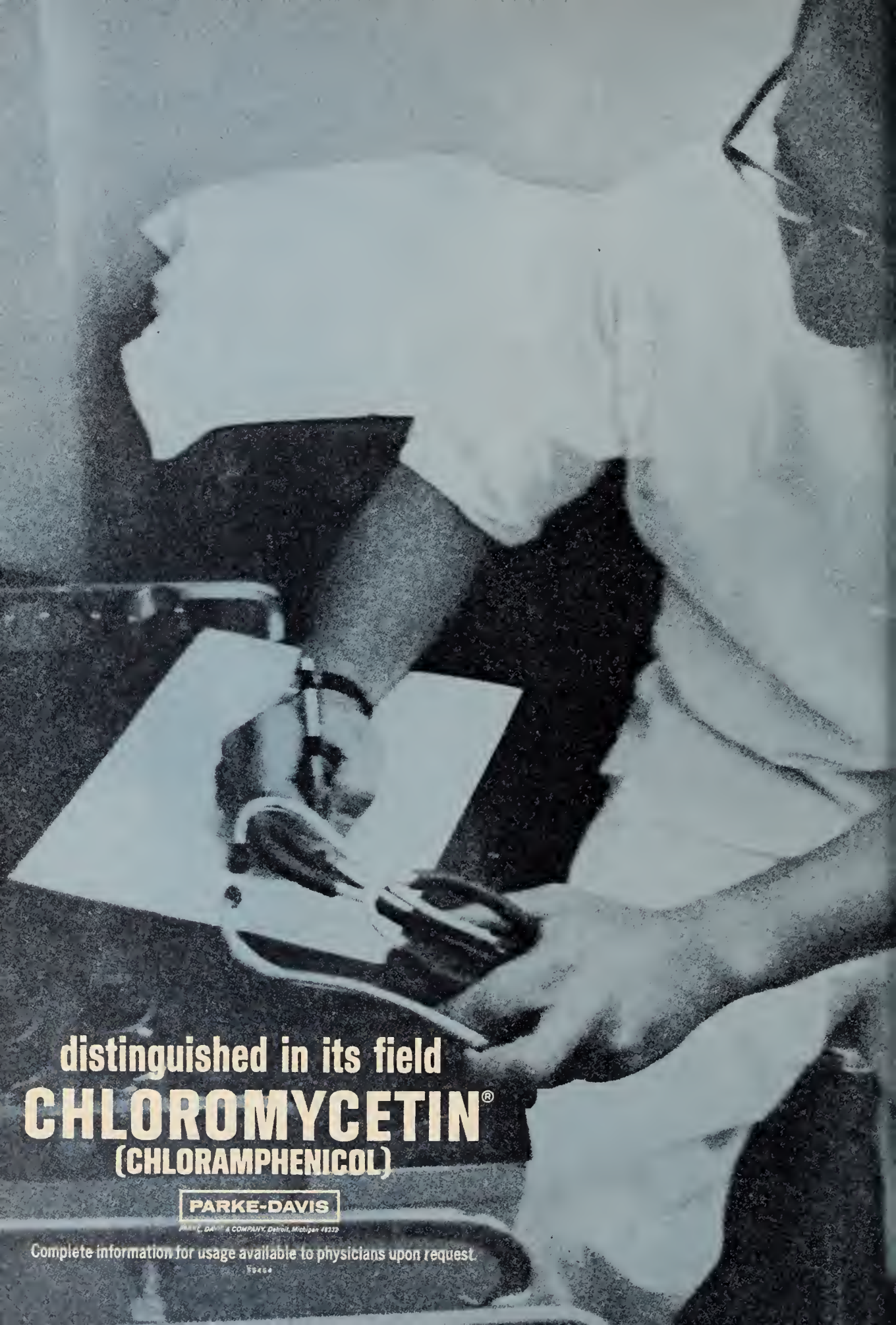
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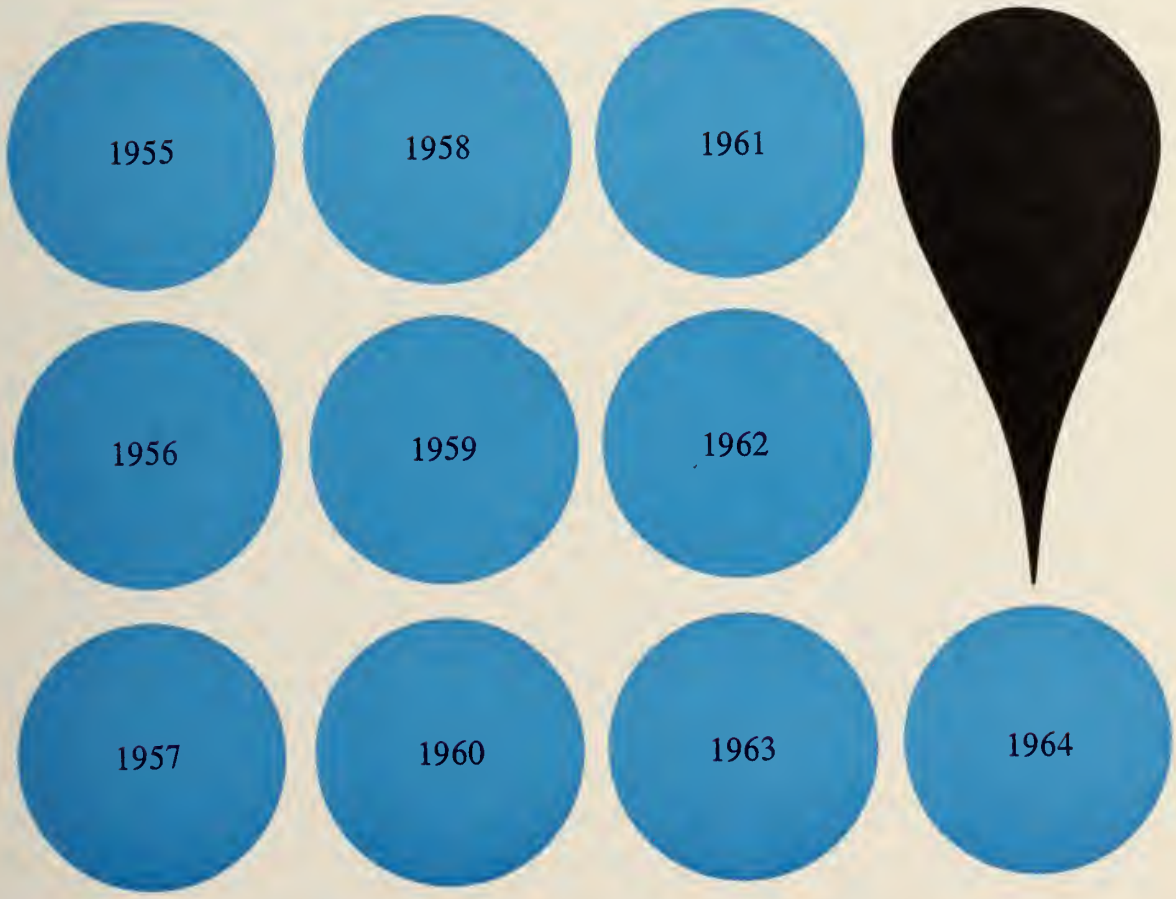
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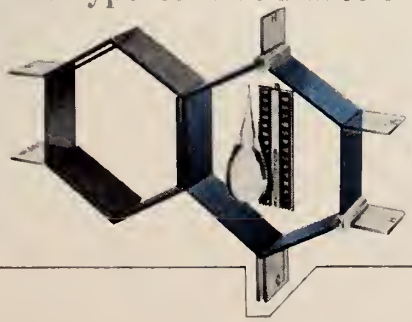
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CONTRAINDICATION: Anuria.

1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. J. Amer. Geriat. Soc. 11:945 (Oct.) 1963.

2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

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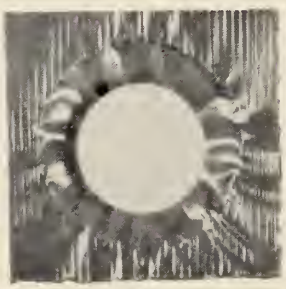
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[1](Journal of Gastroenterology, Vol. 29, page 304)

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Of 1,028 patients with confirmed respiratory infections... 954 or 92.8% were treated successfully with Signemycin®

Note:
Hammerl* selected his patients for treatment with Signemycin on the basis of demonstrated bacteriological resistance to other antibiotics or failure of previous therapy. Of 100 patients with various respiratory tract infections, 95 responded to Signemycin. Pathogens isolated included staphylococci and *Diplococcus pneumoniae*.

*Hammerl, H.: Wien. Med. Wschr. 108:629, July 26, 1958.

Condition	No. of Patients	No. Cured with Signemycin
Abscess, pulmonary	17	16
Bronchiectasis	19	13
Bronchitis	286	267
Bronchopneumonia	192	179
Empyema	12	11
Pneumonia, lobar	150	146
Pneumonia, other febrile	160	150
Various infected pneumopathies	192	172
Totals	1,028	954 (92.8%)

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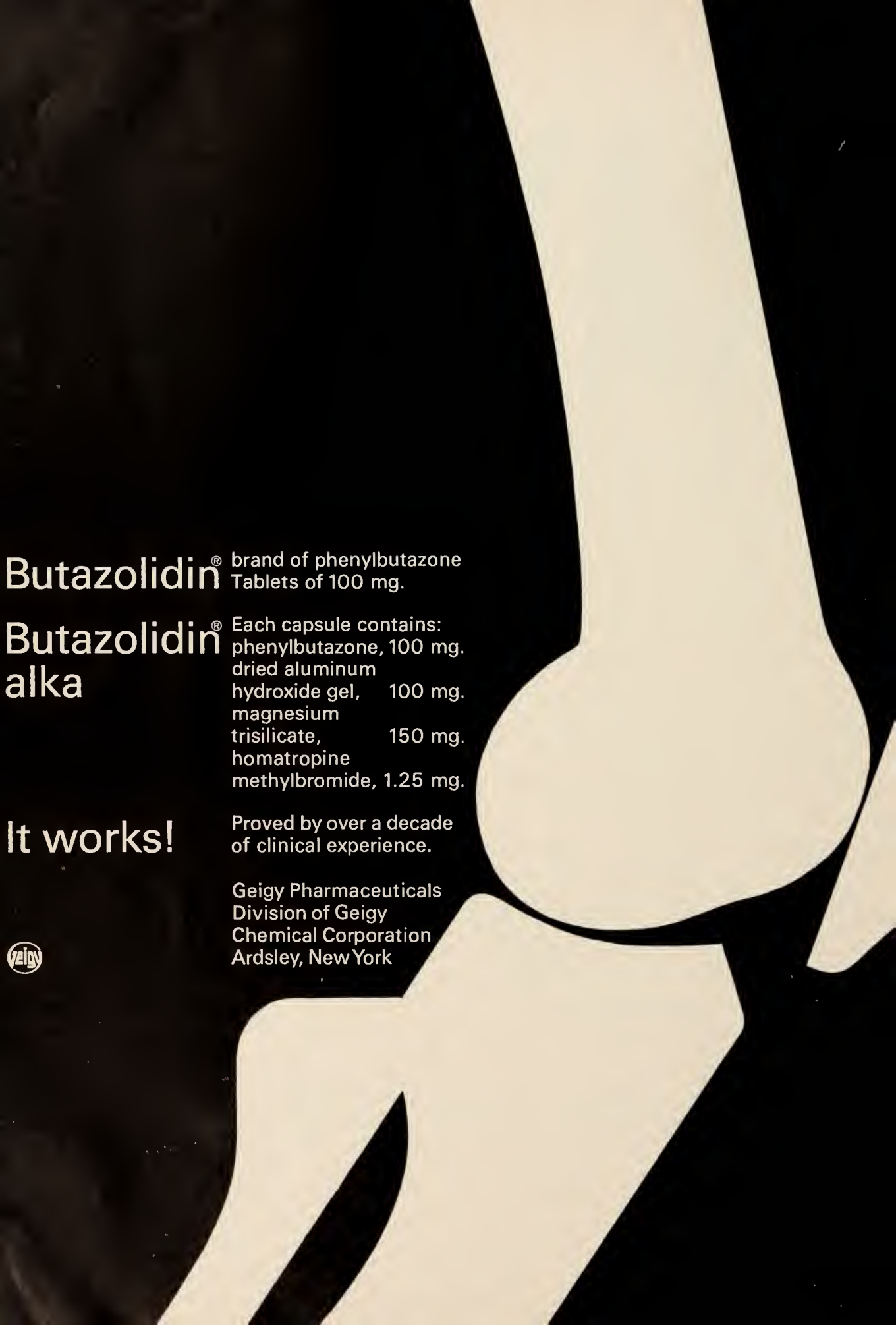
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Note:
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*Adams, J.: J. Tenn. Med. Ass. 50:446, Nov., 1957.

Condition	No. of Patients	No. Cured with Signemycin
Otitis media	90	86
Pharyngitis and laryngitis	162	148
Sinusitis	68	55
Tonsillitis and peritonsillitis	163	153
Various	24	23
Totals	507	465 (91.7%)

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Note:
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Chattas, A. et al.: Antibiot. Med. 7:300, May, 1960.

Condition	No. of Patients	No. Cured with Signemycin
Eye, ear, nose, throat infections	368	343
Respiratory infections	369	346
Gastrointestinal infections	42	30
Skin and soft-tissue infections	38	37
Deep-seated or generalized infections	47	44
Various conditions	157	150
Totals	1,021	950 (93.0%)

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Side Effects: Glossitis and allergic reactions, as well as severe anaphylactoid reactions, have been reported as rare side effects. Should significant reaction or idiosyncrasy occur, discontinue medication and institute countermeasures. Use of tetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. Reduce usual oral dosage and consider serum level determinations in patients with impaired renal function to prevent possible liver toxicity due to excessive accumulation of antibiotic in the serum.

Precautions: Overgrowth of nonsusceptible organisms may occur. In such cases, discontinue medication and institute appropriate specific therapy as indicated by susceptibility testing. Aluminum hydroxide gel given with antibiotics has been shown to decrease their absorption and is contraindicated. The coloring agents used in Signemycin Syrup and Pediatric Drops may produce red discoloration of stools.

Triacetyloleandomycin, a constituent of Signemycin, administered to adults in daily oral doses of 1.0 Gm. (3 Gm. Signemycin) for periods of more than ten days may produce hepatic dysfunction and jaundice. In the rare patient who requires this high dosage level of Signemycin initially, liver function should be carefully followed and dosage should be reduced, as promptly as possible, to the usual recommended range of 1.0 to 2.0 Gm. per day. Therefore, Signemycin is recommended primarily for the treatment of acute or severe infections, with treatment restricted to a ten-day period. If clinical judgment dictates continuation of therapy beyond ten days, serial monitoring of the liver profile should be carried out, including BSP, transaminase, and cephalin flocculation tests. Changes observed in liver function were reversible following discontinuation of the drug.

Formulas: Capsules: 250 mg. Signemycin (167 mg. tetracycline HCl and 83 mg. oleandomycin as triacetyloleandomycin).

Capsules: 125 mg. Signemycin (83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin).

Syrup: 125 mg. Signemycin (tetracycline equivalent to 83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin) per 5 cc.

Pediatric Drops: 100 mg. Signemycin (tetracycline equivalent to 67 mg. tetracycline HCl and 33 mg. oleandomycin as triacetyloleandomycin) per cc.

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Condition	No. of Patients	No. Cured with Signemycin
Ear, nose and throat infections	507	465
Respiratory infections	1,028	954
Gastrointestinal infections	425	387
Genitourinary infections	748	684
Skin and soft-tissue infections	1,088	1,036
Bone and joint infections	71	64
Deep-seated or generalized infections	257	251
Obstetrical & gynecological infections	341	320
Miscellaneous conditions	592	570
Totals	5,057	4,731 (93.5%)

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Primary Carcinoma Of The Fallopian Tube With Abnormal "Jet Washings"

O. Thomas Bolding, M. D.; James R. Williams, M. D.;

W. Nicholson Jones, M. D.

Review of Literature

Primary carcinoma of the fallopian tube, as reported by various authors, is one of the more rare gynecologic malignancies, the incidence varying from 0.1 to 1.1 per cent of all gynecologic malignancies. Sinha gives an incidence of 0.01 per cent of all gynecologic admissions. This is the first case at University Hospital in 12,279 gynecologic admissions and 2,702 gynecologic malignancies in the last ten years. It is our purpose in presenting this case to emphasize the importance of cytologic findings in an effort to make early preoperative diagnosis, and to introduce a new method of intra-uterine sampling which will be reported at a later date.

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Ross, in his report of eight cases in 1962, pointed out that diagnosis had been properly documented only six times preoperatively and mentioned that study of exfoliated cells from the vaginal vault, cervix, and endometrial aspiration had pointed toward the correct preoperative diagnosis in the experiences of Fidler, Fraenkel, Weekes, Brewer, Calle and Phillips. Bochner has stated that a malignant growth of the tube must be considered when positive vaginal cytologic findings are associated with normal cervical biopsy and normal curettings. We would agree with this statement.

Sedlis conducted a questionnaire review of 226 cases of primary carcinoma of the fallopian tube over the past decade. He found 24 positive cytology smears on smears obtained on 40 patients. Hu, in 1950, reported the positive finding of polyhydric, fatty, degenerated

cells on colpotomy as being highly suggestive of malignancy.

Almost all authors have pointed out that increasing the five-year survival rate depends on early diagnosis, as with other cancers. As stated by many authors, the clinical picture is not diagnostic. This is also evident from the very sparse number of preoperative diagnoses in the literature. In the majority of cases, the physical findings are masked by the presence of uterine fibroids, old chronic P. I. D., ovarian cysts, and pathology occurring in the older childbearing age group. Sedlis, in his review of 226 cases in 1962, gives only a 5 per cent incidence of the concomitant occurring triad of pain, metrorrhagia and leukorrhea, and ten cases in 232 with hydrops tubae profluens.

It therefore appears that a positive cytologic exfoliative smear in the face of negative cervical biopsy and uterine curettage has become the most frequently occurring suspicious sign, particularly in asymptomatic patients in whom surgery can effect cure.

Case Report

History and Physical Examination: E. L. P. unit No. 72100. A 50-year-old colored female, gravida one, para one, was admitted from the emergency room for evaluation of "heavy" uterine bleeding and pelvic tumors. She had been having excessive and prolonged menstrual periods for several months prior to admission. She further stated that she had occasionally noticed spotting between periods after "family relations," and more rarely had noticed a foul, watery discharge between periods. Pelvic heaviness and constipation, with moderate urinary frequency, were the only other significant facts of the present illness history. There were no significant positive findings on physical examination other than those limited to the pelvis. She was found to have estrogenic mucosa; there were no abnormalities of the vulva other than staining with old and fresh blood. The cervix was displaced to the left and somewhat anteriorly. Adnexal areas were thickened and moderately tender but could not be definitely separated from fundal mass, which was the size of a five months' gestation. The cervix was free of obvious lesions, but blood trickled from the os.

Laboratory Findings: The PCV on admission was 25 mm. Prothrombin was 100 per cent. Urinalysis was negative and within normal limits. Frog test was negative. Bleeding and clotting times were normal. IVP was normal other than extrinsic pressure defects of fibroid tumors. Chest X-ray was normal other than mention of calcified hilar nodes of the right. FBS was 190 and repeated the next morning, showing 136 (attributed to I. V. fluids).

Course in Hospital: The patient received multiple transfusions and then D&C was done. The uterine cavity was sounded to a depth of 6-½ inches and was found to have a marked irregularity of the cavity. The curette confirmed the suspicions of a large submucous fibroid, and curettage was difficult to perform. Uterine "jet washings"* and cervical biopsies were obtained.

Pathologic examination of the tissue submitted revealed:

"1. Fragments of cervix uteri showing squamous metaplasia

2. Fragments of smooth muscle showing chronic inflammatory reaction and moderately dysplastic epithelium. Comment: No endometrium is represented. The dysplastic epithelium is squamous and probably cervical in origin. The dysplasia may be a response to the chronic inflammation which is present."

3. Jet washings were Class V. (Reports available after surgery).

*The jet washer is a device for obtaining endometrial material by a negative pressure method. This device has been in use approximately five years at this hospital and by many private physicians of the community.

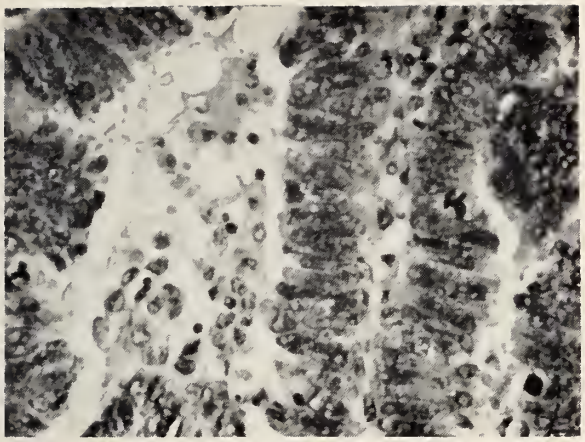


Figure 1

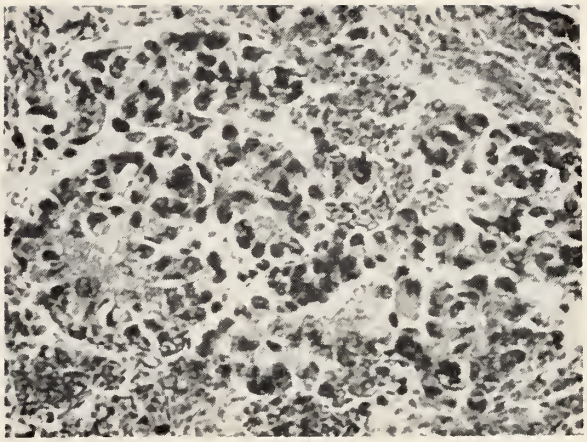


Figure 2

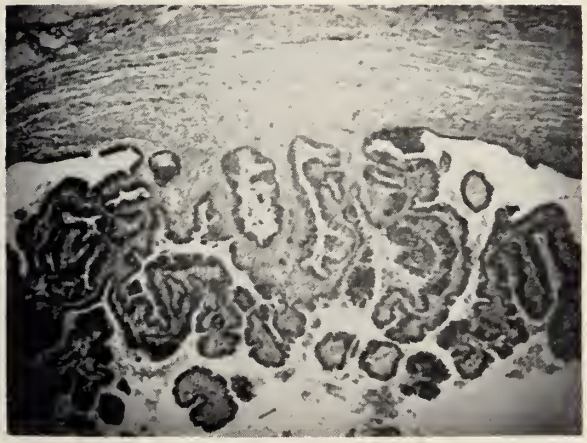


Figure 3

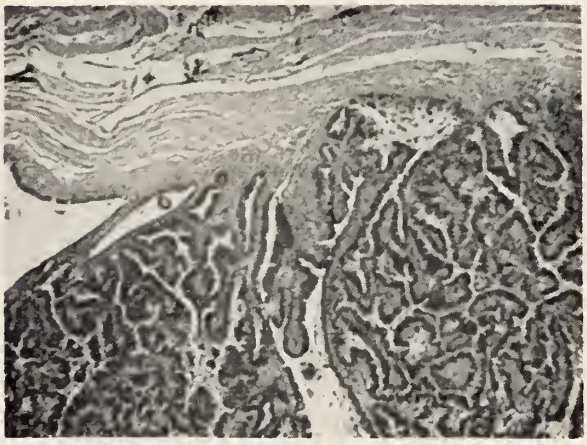


Figure 4

The patient then had an exploratory laparotomy. She was found to have multiple uterine fibroids and evidence of old pelvic inflammatory disease. The tubes were grossly enlarged and densely adhered to the uterus with adhesions. A total hysterectomy and bilateral salpingectomy were done. The right ovary was identified but not removed because of surgical technical difficulties. The ovary was grossly normal in appearance other than numerous adhesions binding it to the pelvic wall. The left ovary was removed in the dissection. The postoperative course was uneventful and the patient was discharged on the 8th postoperative day. She is asymptomatic, with negative pelvic findings on three outpatient clinic visits since discharge.

Final Pathologic Reports: The uterus and myoma weighed 915 Gms. The uterus showed basal endometrium and multiple leiomyomata (subserous and submucous). The left fallopian tube, chronic salpingitis. The right fallopian tube, probably primary carcinoma. Comment: "The neoplasm in the right fallopian tube is papillary and does not infiltrate beyond the mucosa. We can exclude the endometrium as a possible primary site, but not the ovaries, as they are not available for examination. With this reservation I feel that the neoplasm is quite compatible with origin in the fallopian tube."

Discussion: This is the first reported case of primary carcinoma of the fallopian tube at the University Hospital. This patient did not have a correct preoperative diagnosis, which is not unusual after reviewing the other reported cases. Pain in the lower abdomen, vaginal discharge, and a pelvic mass were features of this case and are characteristics of this disease as reported by many others.

This patient was admitted for evaluation of pelvic tumor (thought to be fibroids) and received the usual work-up, including D&C and cervical biopsy. These studies were negative, and exploratory lap was done for removal of large uterine fibroids.

At the time of surgery we were concerned most with removing large uterine fibroids. The problem was compounded by the residuals of old P. I. D. The intent was to do a total abdominal hysterectomy with bilateral salpingo-oophorectomy. Due to technical difficulties the small, fibrotic, benign appearing left ovary was not removed with the specimen. This was unfortunate, since carcinoma was detected in the opposite tube. After careful review of the slides by ourselves and the members of the Pathology Department the diagnosis of primary carcinoma of the fallopian tube seemed justifiable. The tumor was well contained in the tube, with no apparent invasion or distant spread. (See photographs). For this reason the patient did not receive any post-op irradiation.

Five year survival figures are not good with this disease. Sedlis mentions a 23 per cent five year survival. The range is from 5 per cent to 40 per cent by others.

What are the chances that you can detect tubal carcinoma by routine Pap smears? Sedlis again mentions 24 out of 40 patients (60 per cent) had abnormal cytology. This compares with the detection rate for endometrial lesions in many series. Our report varies somewhat in that the exfoliated cells were correctly detected by the "jet washings" and missed by the D&C and cervical biopsy. Pap smear was not done due to bleeding. A report of the "jet washer" and explanation of its function is forthcoming.

Summary: This is a report of a primary carcinoma of fallopian tube and the first such case seen at the University Hospital. This patient had associated P. I. D. and fibroids. D&C and cervical biopsy were negative, but material taken from the uterine cavity by a new device, the "jet washer," showed material that was considered Class V by the pathologist reviewing the slides.

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Counseling With Parents Of Children With Abnormal Speech And Language Development

Marjorie Washburn Rittenour, M. A.

Montgomery, Alabama

The speech pathologist is often the first person to examine a child for reasons of delayed development in speech and language. A large number of children are referred to the speech pathologist by pediatricians and general practitioners because the child is using no speech or is speaking with such unintelligible jargon that even the parents have to guess the meaning of his communicative efforts. If the child is in good physical health and there are no gross neurological abnormalities evident, the physician often believes that the major part of his role is finished and prefers someone else to undertake the differential diagnostic task and the interpretation of the findings.

The professional person who first confronts the situation is charged with initiating counseling of the parents. Although neurological, audiological, speech and language evaluation, and social work investigation of the child are involved in a complete study of the patient, the responsibility for this parent counseling is uniquely critical. The adeptness with which it is managed determines parental acceptance of referral to other specialists. The counseling of these parents may eventually be limited by the area of medicine within which the counselor operates. However, the beginning counseling sessions may open or close the door to early diagnosis and help. Therefore, skills in guidance and counseling become the foundation for effectiveness in any therapeutic endeavor for parents of the child with delayed development.

Mrs. Rittenour is chief speech therapist, Speech and Hearing Services, Central Alabama Crippled Children's Clinic, Rehabilitation Center.

Limitations in Interpreting Diagnostic Findings

"One-shot" evaluations are of little value. Results may be too often denied or distorted by the parents and signal a start on the dreary rounds of looking for someone who will speak the hopeful words that parents want to hear.[4] A service that carries with it the sincere wish to share the burden of long term problems will enable parents to accept a current interpretation of their child's problem. This is not a conscious effort of withholding information. It is a realization that the time and final expression of a child's handicap and potential cannot be predicted but must evolve from the parents' use of the definition of the problem given to them, as well as the environment of the home, and the encouragement and love of parental figures and other siblings.

When a child is not talking and/or shows other evidences of serious mental, physical and/or emotional retardation, real courage is required for parents to accept him at his present level of functioning and to revise their standards for him accordingly. There are many things the child obviously cannot do well—play happily with children his own

age, finish a small task, inhibit irrelevant or hyperactive behavior—but the question is, "What can he do that is acceptable or mildly helpful to himself and those about him?" Parents need help in recognizing the child's own growth impulses and in understanding the importance of building on these instead of attempting to hasten the child's maturation (which no one can do) or to reduce the deficiency (which he alone can do).[2]

The Parents' Role

It is apparent that what the parents are to a child who is not talking or generally retarded is more important than what they do. They should concern themselves more with the child's security than with his deficiency, create time for him for learning instead of time for him to be taught, and attempt to accept him as he is instead of molding him into what they think he ought to be.

Implementing this kind of parent-child relationship is a highly individualized matter. Since parents differ, their resourcefulness in a particular situation may often exceed any set of directions given by the counselor. How parents can be encouraged to develop in the child attitudes of independence, self-control, understanding, and co-operation is the problem facing anyone who has a part in the counseling process.[5] Parental acceptance can never be accomplished in one or even a few interviews. There must be a development process through which a parent passes before adequately recognizing the problems of his own child. The length of time is influenced by personality characteristics of the parents and varies with the strength of these factors. But it depends also on the nature of the counseling process and the manner in which it is conducted.

Attitudes of the Parents in Counseling

In the past, concepts of counseling focused on the diagnosis of the problems and interpreting the diagnosis to the parents with specific bits of advice.

If most parents were able to maintain a healthy, realistic attitude toward the child, recognizing his deficiencies and limitations, making appropriate concessions to the facts, then this concept of counseling would be adequate. But, painful experience to the contrary has strongly indicated that such an approach is beneficial to neither the parent nor the child. The point, so often overlooked and unappreciated, is that the behavior of the parents does not result from logical intellectual processes. It results from their own mental conflicts, their tensions, anxieties, guilt feelings. To function better, they require, not merely more information regarding child management, but sufficient relief from their own emotional disturbances so that they can be free to exercise good judgment.

Basic to the relationship between parent and counselor is the acceptance of the parent as a worthwhile person no matter how confused, uninformed, misinformed, or occasionally belligerent he may be. Acceptance implies neither approval nor disapproval of a person's behavior. It is closely related to deeply understanding the individual's words, attitudes, and feelings from his point of view. The atmosphere of acceptance, understanding and respect is a profound force in freeing the parent to move forward on his own, to see the problems he and his child face with greater clarity. In the first contact, the counseling process with the parents should be tentatively defined. Simply labeling the symptoms in the child is no solution to the problems involved for the parents. They must be made aware that the counselor does not have a list of answers to some of the complexities of the problems they face. This approach in no way necessitates avoiding a description of the child's developmental delay. Indeed the responsibility of the counselor tends toward assisting the parents define his deviations from usual development in operant terms. First, he encourages the parents to describe the child's behavior by telling what the child does in specific situations. Objectively looking at behavior, describing what actually happens rather than interpreting it, sometimes quite inappropriately, is important in helping the parent to obtain new perspectives of the child and to see possibilities for change.

Such general terms as he's "lazy," "uncooperative," "stubborn," or "mean," are shifted to more descriptive terms to show what the child does that is construed as "lazy," etc. Second, the counselor encourages the parent to express his feelings regarding the child. Anxiety, guilt, concern, hostility, and other negative feelings are recognized with neither approval nor blame. Full release of these feelings with clarification of them opens the way for expression of positive impulses that make for growth and independent action on the part of the parent.

Unfortunately parent counseling is often assumed to be the offering of suggestions to parents, providing direct answers to questions, and advising on management of all the complexities of human interpersonal relationships. This is a far cry from helping the parent to find for himself answers to his problems, understand his own behavior in relation to the problems, and identify new possibilities for action in areas where he has been blindly groping.

Attitude of the Counselor

A critical attitude in relationship to the parent can be no more productive than a critical attitude in relationship to the child in any therapeutic process. The starting point in parent counseling must be based on the realization that although the child presents symptoms of retarded development, the parent is reacting to these symptoms with anxiety and that the child in turn reacts to the anxiety of the parent. This circular reaction occurs in various degrees in all parent-child relationships whether the etiology of the child's delay lies in mental retardation, brain injury, profound hearing loss, or psychogenic factors.

The counselor who attempts to point out to the parents all the wrong things they have done and to instruct them in new techniques in the handling of the child, walks into the very trap the parents have set. The counselor, in being critical of the parents, is substantiating their feelings of inadequacy and failure. Parents' obedience in following suggested techniques may give the impression of non-resistance to treatment, but more often it is the parents' way of giving the responsibility to the counselor. If the parents follow to the letter the orders of the counselor and the problem continues, then it is the counselor who has failed rather than the parents. If the child responds to the new techniques employed, then the parent is relieved of ever examining the causative and perpetuating factors.[7]

Although much emphasis in parent counseling is on acceptance of the parents and reflection and clarification of their feelings, it is commonly agreed that a range of techniques may be utilized to adjust to the requirements of the situation. When non-directive techniques are used, counselors need to know their limitations for rigidity in their use can cause as much resistance to change as the ineffective use of any other techniques.[3]

Group Parent Therapy

Counseling with parents varies in depth. From the first contact, the parent is guided in defining the child's problem. The manifestations of deviation are discussed and the bases of his eligibility for therapy are defined. This beginning of the counseling process we may call guidance. Either accompanying this initial session, or following very closely, is the second phase which we may term counseling. Counseling, in this sense, shifts in emphasis from dwelling on the problem per se to the expressions of feeling of the parents regarding their frustrations in management of the child. This level of counseling may be extended considerably in time depending on the individual ability of the parent to relate with freedom and purpose. Soon, however, the third aspect which we may call group parent therapy may be utilized.

As parents are able to face their problems and their anxieties regarding his problems, it is this third phase of experience that promotes the opportunity with parents for (1) attempting to solve problems of relationships and behavior, (2) sharing many solutions to practical problems, (3) releasing deep concerns of the parent in the company of several other persons, and (4) reinforcing each

other in trying out various means of coping with these problems. Although these three aspects are delineated as graduated steps in parent counseling, elements in each overlap. There may be occasion for some guidance in individual counseling and group counseling. But this would not be a basic emphasis in later counseling as the entire process moves forward in each parent's assuming the responsibility for making decisions and experimenting with new solutions.

Conclusions

Parents of children with retarded mental, physical, and/or psychological development come at first expecting to receive answers for their problems. Sensing the child's delay in responding to growth stimuli all around him, they seek information about methods they can use to bring the outer world and its concepts to bear on his learning. As the parents experience an environment of acceptance but not one providing ready-made answers, they begin to ask questions of themselves and of the relationship of their own anxieties to the problems centered around the child. They learn to accept with less guilt and confusion tentative aspects of the diagnosis. As counseling progresses, the reduction of psychological barriers such as not accepting the child and their own hostility, enables them to modify their handling of the interpersonal relationships at home.

Evidence increases of what they and other parents are able to do on their own in the structure of counseling. Positive changes are reflected in behavior recurring in the children between the sessions in therapy. It becomes increasingly clear that with even a little help parents can make a profound contribution in reducing controllable barriers to growth in their developmentally delayed child.[1]

In summary, counseling with parents of children who have extensive mental, physiological and/or psychological anomalies is a comprehensive task. The functions of such a counselor include (1) guiding the parents in defining the problem, (2) reflecting parent feelings in relation to their perceptions of guilt, anxiety, and the like, and (3) serving as a catalyst in helping parents explore and alleviate their sense of helplessness, anxiousness, and self-condemnation. These functions so profoundly affect the well-being of the entire family that they may be considered indispensable to an adequate treatment program.

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Tuscaloosa, Alabama

I. Etiology

Hyperinsulinism and hypoglycemia are not synonymous—hyperinsulinism is only one cause of hypoglycemia. Conn and Seltzer[1] divide the hypoglycemias into three groups: organic, functional, and factitious. Organic causes of hypoglycemia are hyperinsulinism, liver disease, anterior pituitary hypofunction, adrenocortical hypofunction, large fibromas or sarcomas, and central nervous system lesions. The only proven causes of organic *hyperinsulinism* are tumors or hyperplasia of the pancreatic beta cells. Functional hypoglycemia exhibits no recognizable anatomic lesion, but is explainable on the basis of unusual somatic function. Its two main forms are thought to be due to autonomic nervous system imbalance or rapid intestinal absorption of sugars with a so-called "rebound phenomenon," as is frequently seen after gastroenterostomy or gastric resection.[2] Factitious hypoglycemia is due to surreptitious insulin administration and should be suspected in persons with hypoglycemia who have easy access to insulin such as doctors, nurses, and relatives of diabetics.[3]

There is a recently described association between large fibromas or sarcomas and hypoglycemia[4]. Several cases have been described, but the mechanism of action is not definitely known. Hines[5] considered that any of three methods might be causative: 1. a product of the tumor might exert a direct action on the pancreatic beta cells causing excessive production of insulin, 2. the tumor might itself utilize excessive amounts of carbohydrate, and 3. some product of the tumor might act directly to lower the blood sugar. August and Hiatt[6] feel that these tumors liberate an "insulin-like" substance and this is the most popular theory at the present time.

II. Historical Background

The pancreatic islets were first described by Paul Langerhans in 1869. As early as 1884, Arnozan and Vaillard ligated the major pancreatic ducts to produce atrophy of the pancreatic acini with persistence of the islets. Von Mering and Minkowski proved experimentally in 1890 that total pancreatectomy in animals produced the clinical picture of diabetes mellitus. In 1893 Laguesse named the islets for Langerhans and suggested the possibility of their having an endocrine function. Nicholls described the first islet cell adenoma in 1902. Lane, working with guinea pigs in 1908, described alpha and beta cells in the islets, and speculated that although they may be only different phases of the same cell, they might secrete different substances. In 1912, Bensley demonstrated in guinea pigs that the islets originate from the pancreatic ducts.[7]

During this period, many efforts were made to prove that the islets had an endocrine function, but none were successful until the experiments of Banting and Best in 1922. After ligating the pancreatic ducts of living animals, they were able to isolate intact islet cells. An extract of these cells ("insulin") produced hypoglycemia in animals, and completely changed the treatment of human diabetes mellitus.[8]

Harris, while visiting Banting's clinic in 1924, remarked that he had seen non-diabetic patients in private practice with symptoms similar to those that Banting had found to be

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due to insulin overdosage. Harris coined the term "hyperinsulinism" and spent much of his life in its study. His first patient with the condition was a physician seen in March, 1923. Harris also wondered if this condition was associated with dysfunction of the pituitary thyroid, and other endocrine organs.[9]

In 1926, a physician was seen at the Mayo Clinic with a 19 month history of weakness, weight gain, and recent coma and convulsions coming after long periods without food. A fasting blood sugar (Folin-Wu method) was 27 mg. per cent and liver function studies were normal. Dr. Russell Wilder diagnosed hyperinsulinism and the patient was explored on December 4, 1926, by Dr. William Mayo. He was found to have a large tumor in the tail of the pancreas and multiple liver nodules. Liver biopsy revealed metastatic islet cell carcinoma, and no further surgery was done. The patient died 30 days postoperatively and at autopsy one of the liver nodules was found by assay to contain 40 units of insulin activity/100 gms. of tumor. The surrounding normal liver tissues contained no insulin activity. This substantiated Banting and Best's claim that insulin is produced by the islet cells.[10] Two years later, Roscoe Graham performed the first successful resection of a functioning islet cell adenoma.[11]

III. Pathology

Various autopsy series have shown that islet cell tumors were present in from 0.1 per cent to 1.0 per cent of cases.[12] Most functioning islet cell tumors occur in the fourth through sixth decade of life, but cases have been found in newborns and septuagenarians. No apparent sex difference has been noted.

In a large series the tumors were found throughout the pancreas, with 32.5 per cent being in the tail, 24.6 per cent in the body, 25 per cent in the head, and the rest at the junctions of the three parts. Three per cent of the collected cases were found in ectopic pancreatic tissue, usually in the vicinity of the duodenum.[13] Over 10 per cent of the patients had more than one adenoma found either at the initial operation or subsequently. Islet cell adenomatosis, with large numbers of tumors, occurs only rarely. Some authors believe that islet cell hyperplasia is a cause of hyperinsulinism.[14,15]

Seventy-five per cent of islet cell tumors were between 1.0 and 3.0 cm. in diameter with some as large as 10-15 cm. and others as small as 5 mm. Tumors smaller than 1 cm. are very difficult to palpate at the time of surgery.

Pathologically the tumors are classified as benign, suspiciously malignant or grade I, and frankly malignant.[16] Moss and Rhoads collected 766 cases of functioning islet beta-cell tumors in the world literature through December 1957. They found 74.9 per cent to be benign, 12.9 per cent to be suspiciously malignant, and 12.1 per cent to have obvious metastases. Grossly, the benign tumors are well-defined and encapsulated with a smooth or lobulated surface. The cut surface is reddish-gray, often homogeneous, and richly vascularized. Microscopically, the tumor resembles a large islet with masses of cells without any particular arrangement. A few mitotic figures may be present. Fibrosis, hyalinization and calcification are common.[17,18]

Suspiciously malignant, or grade I adenocarcinomas as they are called, have the histologic picture of malignancy but without demonstrable metastases. It was thought at one time that these tumors would never metastasize, but recent reports have shown that this occasionally happens.[12] Frankly malignant tumors by definition have metastases. Microscopically they show atypical mitotic figures, large nucleoli, invasion of vascular channels, hemorrhage, and necrosis.

It is impossible to differentiate histologically between functioning and non-functioning tumors, although hyalinization may be prominent in active tumors and there may be associated degranulation of normal islets.[18]

IV. Symptoms of Hypoglycemia

Richardson and Hill divide the symptoms of hypoglycemia into two categories, metabolic and cerebrospinal.[19] Metabolic symp-

toms are mainly the result of hyperadrenalinemia brought on by a precipitous drop in blood sugar. They consist of any or all of the following: sweating, flushing, pallor, numbness of the circumoral region, epigastric pain, trembling, dizziness, hypertension, cardiac palpitation, and syncope.

The cerebrospinal symptoms are the result of the great dependence of the brain on a normal amount of circulating glucose. The brain is the only organ in the body to metabolize predominantly carbohydrates, and it has only a meager supply of stored carbohydrate in the form of glycogen. With a reduction of metabolism during hypoglycemia, the brain cannot utilize the oxygen it needs and the resulting anoxia causes functional and anatomic damage to the brain. The oxygen uptake by the brain may decrease from a normal of 6.8 vols. per cent to 1.8 vols. per cent during extreme hypoglycemia. The clinical changes begin with the higher brain functions and descend phylogenetically; the older parts of the brain, with their smaller oxygen requirements, being more resistant to lower oxygen levels. Chronic alcoholism, arteriosclerosis, or prolonged chronic infection tend to make the brain more susceptible to hypoglycemia.

Gradual reduction in the blood sugar causes mainly cerebrospinal symptoms which may be episodic or continuous. Episodic attacks tend to occur at set times in the same individual such as early morning, but they may vary in severity. With focal reduction in neuronal function, there is numbness, slurred speech, diplopia, vertigo, paralysis, and/or automatism. Diffuse neuronal involvement causes confusion and psychic episodes, and if severe enough to cause acute encephalopathy, prolonged coma may result. Besides loss of neuronal function, there can occur neuronal irritation, either alone or in combination with other symptoms, and focal or generalized epileptic seizures are the result.

Permanent brain damage from repeated or prolonged hypoglycemia is responsible for continuous symptoms. These range from mild, progressive dementia to dysphasia, paralysis, striatal symptoms, and myelopathy. Deep coma from hypoglycemia can terminate in death.

If the decrease in blood sugar is rapid, profound, and persistent, the metabolic and cerebrospinal symptoms may occur simultaneously.

Moersch and Kernohan feel that a severe attack of hypoglycemia can be divided into four definite stages.[21] The prodromal stage, lasting 10-30 minutes, finds the patient exhibiting mental and physical retardation with confusion, irritability, and restlessness. This passes into another stage with increase in confusion, or with agitation and delirium lasting as long as several hours. The third stage consists of stupor or coma and is characterized by marked perspiration and salivation with variable convulsive phenomena, changes in reflexes, nystagmus, and motor palsy. The recovery stage may be rapid or slow depending on whether it is induced by drugs or glucose or occurs spontaneously. In this stage, dullness and apathy may persist for several hours.

An "attack," consisting of any or all of the above symptoms, usually occurs after a period of fasting, so most commonly it is seen in the early morning hours before breakfast, or in the late afternoon if lunch is skipped or is of insufficient caloric value. Strenuous or prolonged exercise may also cause or aggravate the symptoms.[22]

V. Diagnosis

Whipple proposed a triad of conditions to be met in the diagnosis of hyperinsulinism:[7] 1. attacks, as described previously, occurring in the fasting state, 2. hypoglycemia with blood sugar of 50 mg. per cent (Folin-Wu) or less during an attack, and 3. relief of symptoms after administration of glucose. This has been a helpful standard, but not 100 per cent reliable with both false positives and negatives occurring. In 110 cases, the lowest blood sugar during an attack was 45 mg. per cent or less (Folin-Wu method) in 107 patients, but

this included 15 patients who were later found to have a normal pancreas.[15]

The most commonly used diagnostic tests, in addition to the routine fasting blood sugar, have been the response to a prolonged fast, the tolbutamide tolerance test, and the L-leucine tolerance test.

For the fast, the patients are hospitalized and given only tea, black coffee, and water, and are encouraged to be active. The fast is continued until symptoms develop, at which time a sugar determination is done, or until 72 hours have elapsed, at which time the test is considered negative. Sixty-six of 89 patients developed significant symptoms within 24 hours, and only two patients developed symptoms after 48 hours. Two patients with negative tests were later found to have adenomas.[15]

Intravenous administration of sodium tolbutamide in a dose of 30 mg./kg. of body weight will produce a significantly decreased fasting blood sugar in most patients with insulinomas as compared to normal individuals, and the hypoglycemia will persist for several hours unless treatment is instituted.[23] Levo-Leucine given orally in a dose of 150 mg./kg. of body weight produces a similar picture, but not as consistently as tolbutamide.[15] Glucose, insulin, and epinephrine tolerance tests have largely been abandoned.

VI. Differential Diagnosis

Other causes of organic hypoglycemia include hepatic diseases, adrenal or pituitary insufficiency, central nervous system lesions, and large fibrogenic tumors.[1] Tests for these conditions include: liver function studies, the eosinophilic response to epinephrine and ACTH, measurement of adrenal hormones in blood and urine, X-ray of the sella turcica, and electroencephalogram.[16]

The attacks of functional hypoglycemia usually occur within a few hours after meals of high carbohydrate content in patients with emotional problems. They practically never cause unconsciousness and the blood sugar during an attack is usually above 50 mg. per cent.[12]

Factitious hyperinsulinism should be suspected in patients with typical attacks who have access to insulin, such as doctors, nurses, and relatives of diabetics. They go to great lengths to conceal their insulin and several have undergone surgery because the true diagnosis was not appreciated.[3]

As can be seen, the diagnosis of hyperinsulinism can be quite straightforward or very elusive. Allan believes the difficulty is compounded because the symptoms when mild are essentially subjective; when severe, they are not pathognomonic; and in most cases the physician must conduct the initial study at a time when the patient is asymptomatic.[17]

Initial diagnoses have included epilepsy, chronic nervous exhaustion, psychosis, cerebrovascular accident, and hysteria among others.[15,21]

As with any disease, the correct diagnosis in these patients depends on an awareness of its possibility, a carefully taken history and the adjunctive tests as listed above.

VII. Treatment

The treatment of choice for islet cell tumors is surgical removal of the tumor. However, Moss and Rhoads list four reasons why medical management may be necessary: 1. the patient may refuse surgery, 2. the surgeon may feel that the risk is too great at that time, 3. the patient with mild symptoms may want to give a medical regimen a trial before resorting to surgery, and lastly, 4. patients with inoperable metastases may need palliative management.[12]

The acute hypoglycemic episode is treated with intravenous glucose with or without epinephrine. Long-term programs have included: 1. low carbohydrate, high fat, high protein diets, 2. ACTH and cortisone, 3. treatment with alloxan, and 4. premeal insulin. Of these four, only the first two have merit, and individual cases have responded to these methods for prolonged periods.[12,17]

Marble[20] advances four reasons for preferring surgical treatment as soon as the diag-

nosis is made: 1. if all benign adenomas are removed, complete cure may be expected, 2. medical treatment is usually unsatisfactory, 3. delay in treatment with continuance of attacks may produce irreparable damage to the central nervous system, and 4. delay may allow the development of obesity.

Unfortunately, most patients have found that taking frequent meals of high carbohydrate content will reduce or prevent the attacks. If there is delay in seeing a physician or postponement of operation, obesity may become a significant factor, not only in surgical morbidity and mortality, but in increasing the difficulty of locating the adenoma.

Four operative procedures are useful in the surgical management of these tumors.[14,17] When a circumscribed adenoma is found in an accessible location, simple enucleation may be sufficient. Distal pancreatectomy is recommended if the adenoma is in the tail. Subtotal pancreatectomy is necessary for lesions in the body or neck of the pancreas. Total pancreatectomy is a formidable procedure and is reserved for lesions of the head of the pancreas or when lesser procedures have not been curative. Waugh, Dixon, and Clagett list four criteria to be met before doing total pancreatectomy in this disease:[24] 1. the patient's symptoms are due to spontaneous hypoglycemia, 2. the tumor is not in the tail or body, 3. if the tumor is in the head and palpable, a local excision is not possible, and 4. the symptoms and disability produced by the tumor must outweigh the magnitude of the operation and the resulting metabolic disturbance.

The surgical approach is as follows.[14,15,22] Glucose is started intravenously before the patient is taken to the operating room. A bilateral subcostal incision is made extending far laterally. The abdomen is then explored with special emphasis on detection of ectopic pancreatic tissue, especially around the stomach or duodenum. The pancreas is visualized by dividing the gastrocolic omentum, mobilizing the pancreatic tail by bringing the spleen forward, and elevation of the head by use of the Kocher procedure on the lateral duodenal attachments. The peritoneum along the upper and lower borders of the gland is incised. The pancreas is then thoroughly inspected and palpated. Adenomas are usually darker than the surrounding tissue and are firm and encapsulated. The tumors are frequently not seen and palpation must be relied upon.

Visible or palpable adenomas are removed by the methods listed above. If no tumor is found, then the surgeon faces a dilemma. The predominant feeling is that resection of the gland up to the region of the superior mesenteric vessels should be undertaken. Examination of this specimen may reveal a small adenoma, or even if no tumor is found, the patient may be relieved of symptoms. If the symptoms persist and the criteria for total pancreatectomy are met, then this procedure is carried out at a later date.

The most common postoperative complications are transient diabetes, pancreatic fistulas, and hyperthermia.

VIII. Results

In 110 patients subjected to exploration at the Mayo Clinic for a diagnosis of hyperinsulinism, 84 were subsequently found to have a benign adenoma or grade I carcinoma and 11 had frank carcinoma with metastases.

Fifty-seven of these patients had local excision of their tumor with four postoperative deaths. Forty-nine of them were cured of their disease. One patient had persistent symptoms and autopsy revealed an islet-cell adenoma. Three other patients developed recurrent symptoms later, with adenomas removed in two patients at second operation.

Thirty-one patients had partial pancreatectomy. Twenty of the specimens contained an adenoma and all these patients were cured with the exception of one postoperative fatality and one recurrence. Eleven specimens contained no tumor, but three of these patients have remained free of symptoms postoperatively.

Six patients had total pancreatectomy, all but one having had previous operations. One

died postoperatively, but the other five were cured of their hypoglycemia.

In Moss and Rhoads' series of 337 operated patients with nonmetastasizing tumors, 81.9 per cent had complete relief of symptoms postoperatively, 5.9 per cent had slight or no improvement, and 8 per cent succumbed in the postoperative period. In 4.2 per cent of cases the follow-up result was unknown.[12]

Summary

In summary, organic hyperinsulinism is produced by tumors or hyperplasia of the islets of Langerhans. Typical symptoms consist of episodes of weakness, confusion or coma, coming on after fasting or exercise, but the clinical picture may be bizarre and the diagnosis difficult. The adenomas may be single or multiple and are classified as benign, suspiciously malignant, or frankly malignant. The 72-hour fast is the most useful diagnostic test. Surgical removal of the tumor is the treatment of choice and produces gratifying results.

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Editorials

PSYCHIATRISTS STUDY WIFEBEATER'S WIFE

Wives who endure physical abuse from their husbands for years finally seek outside help when one of their children, usually the eldest son, interferes, a recent study indicates.

This pattern of behavior emerged in a study of 12 marriages in which the husbands had beaten their wives periodically during 12 to 20 years of wedded life.

The study was reported by Drs. John E. Snell, Richard J. Rosenwald and Ames Robey, Framingham, Mass., in the current (August) Archives of General Psychiatry, published by the American Medical Association.

The couples lived in a predominantly middle-class suburban area, according to the article. The men were referred for psychiatric consultation after court appearances on charges of assault and battery filed by their wives. However, the wives were also interviewed since the husbands proved reluctant to talk to psychiatrists.

The average age of the wives was 37 and they had been married for an average of more than 13 years, the authors pointed out.

"One sees, therefore, that these women were not young brides in the throes of early marital adjustment, but tended rather to be women of mature years whose marriages had shown considerable stability," they commented.

"In no case was the husband's violence of recent onset. Each wife admitted readily that fighting had existed throughout her marriage."

Therefore, the central question became why after 12 to 20 years had these women chosen this particular time to appeal for help outside their families, the authors said.

The wives' first answers to this question almost invariably involved the children in some way, according to the report. Almost all had children over 10 years old. In each of these cases, the eldest was a boy, who figured prominently in the specific episode of violence which triggered the court appearances. In some cases, the eldest boy had taken part in the strife, defending his mother and physically attacking his father.

"The consistency of these observations throughout the group studied gave rise to our speculation that a common significant factor in determining the timing of the court appearance may be the presence in the family of an adolescent child (commonly male) whose intervention in the parents' struggle acts to disturb a marital equilibrium which had been working more or less satisfactorily."

As a rule, the authors continued, the wives were aggressive while the husbands were

passive and shy with a tendency to drink excessively. The wives needed to control the marital relationship and the husbands had strong dependent needs.

The essential ingredient leading to physical abuse seems to be the need both husband and wife feel for periodic reversal of roles; she to be punished, he to re-establish his masculine identity, the psychiatrists said.

So long as the opportunity exists for both to indulge both sides of their conflicting desires, no need for help is perceived by either, they added.

The intervention of the child at a certain age becomes a potentially dangerous threat, they said. It may be at the point that this threat is first clearly perceived that the wife calls for outside help to change a situation which she has fostered but which now appears out of her control, they explained.

HEALTH AND SAFETY TIPS

The American Medical Association's Committee on the Medical Aspect of Sports once again has issued its annual pre-fall admonition regarding early season football practice in hot weather.

Special precautions should be observed to safeguard the health of college and high school athletes at the outset of the season, especially when the practice periods are conducted in very warm and highly humid weather.

The tens of thousands of youths who will shortly be trying to make the school teams all over the nation will be subject to heat exhaustion or heat stroke if care is not observed. Heat exhaustion follows depletion of salt and water due to excess sweating. In heat stroke, the body overheats due to lack of sweating.

The old idea that water should be withheld from athletes during workouts has long since been disproved. In fact, it's necessary to replace water lost through sweating to prevent heat exhaustion. This is best done by occasional drinks of small amounts of water, perhaps half a glass.

Salt needs to be replaced daily, particularly during the acclimatization period. Extra salting of food within the bounds of taste will accomplish this. Salt tablets, particularly on an empty stomach, can be irritating and may be poorly absorbed. Adding one teaspoon of salt to six quarts of water used for drinking during hot-weather workouts offers another approach.

Frequent rest periods during hot weather workouts are recommended. Coaches are urged to watch players closely for signs of lethargy, inattention, stupor, awkwardness or unusual fatigue. Symptoms of water and salt depletion may include headache, nausea, hallucinations and weak and rapid pulse.

The AMA Committee, composed of physicians with particular interest in sports medicine, offers some points to help coaches prevent heat exhaustion and heat stroke in their young players:

1. Require a careful medical history and checkup prior to beginning of practice.
2. Schedule workouts during cooler morning and early evening hours in hot weather.
3. Acclimatize athletes to hot weather by carefully graduated practice schedules.
4. Provide rest periods of 15 to 30 minutes during workouts of an hour or more in hot weather.
5. Supply white clothing (to reflect heat) which is loose and comfortable (to permit heat escape) and permeable to moisture (to allow heat loss via sweat).
6. Furnish extra salt and water in recommended amounts.
7. Watch athletes carefully for signs of trouble, particularly the determined youngster who may not report discomfort.
8. Remember that the temperature and humidity, not the sun, are the important factors. Heat exhaustion and heat stroke can occur in the shade.

SLEEPING SICKNESS— A CASE OF MISTAKEN IDENTITY

Prepared by

The American Medical Association

(EDITOR'S NOTE: In view of confirmed outbreaks of encephalitis in Texas and Florida, and the appearance of encephalitis-like illness in Illinois and Arizona, the American Medical Association is reissuing the following background information. It has been updated to include the latest available medical information on disease outbreaks.)

Viral encephalitis, already posing an epidemic threat in Houston, Tex., may also stage late-summer outbreaks elsewhere in the nation, public health officials have warned.

Confirmed cases of the disease—commonly known as sleeping sickness or brain fever—have been reported in Florida as well as Texas; and suspected cases have been found in Illinois and Arizona.

In addition, the virus has been discovered in certain Florida mosquitoes and horses. The importance of this is that the disease is often spread from animal to man by insect bites and stings.

In fact, insect-borne encephalitis (not to be confused with encephalitis associated with infectious diseases, such as mumps and measles) is strictly speaking a disease of birds and small mammals rather than man, according to Raymond L. White, M. D., director of Environmental Medicine and Medical Services for the American Medical Association.

"Its transmission to man is, in a sense, an accident," he said.

The insects known to transport viral encephalitis generally disdain humans as hosts. But in their short-sighted world they mistake identities and man sometimes gets stung.

Accident or not, encephalitis is serious. The reaction is often severe and the percentage of fatalities among those stricken can range from two to 75 per cent, depending upon which type of encephalitis virus is the infectious agent. In addition, some victims of encephalitis are left paralyzed, enfeebled or mentally affected.

Encephalitis is actually a family of diseases that attacks the central nervous system, explained Dr. White. It is characterized by its sudden onset, high fever, headache and dizziness. Within a day or two drowsiness or stupor overcomes the victim and he often develops a stiff neck, becomes mentally confused and has speech difficulties. In severe cases convulsions and coma may develop. There is no specific treatment.

Insect-borne encephalitis can be found in one form or another in many sections of the world. Three types are known in the United States—Western equine, Eastern equine and St. Louis.

The St. Louis type, identified with the Texas outbreak, gets its name from the epidemic it spread in and around that city in 1933 and again in 1937. The disease ranges through the lower Ohio Valley, all the states west of the Mississippi, as well as Florida. It is much more likely to attack older people and the mortality rate increases steadily with age. Those over 40 and persons with high blood pressure and arteriosclerosis appear to be particularly endangered by the disease.

Western equine, as the name implies, was first thought to be spread by horses. But it later developed that horses, like men, are accidental victims. This form of encephalitis is most prevalent in the Western two-thirds of the nation, but has appeared in several Eastern states as well. It attacks individuals in all age groups, and although considered the mildest form of infectious encephalitis in the United States, it kills about one victim in ten. Children less than one year old are frequently left impaired or retarded by the disease.

Eastern equine, at one time also mistakenly blamed on horses, predominates among children. One study showed that about two-thirds of its victims are under two. It is by far the most serious of the three types and is often fatal. Among young survivors the after effects are often severe. Fortunately, the disease is rather infrequent and seems to be

restricted to certain areas along the Atlantic and Gulf coasts. The highest number of outbreaks is usually in September.

The viruses of encephalitis, once introduced into the body, work their havoc on the spinal cord and brain. They disrupt or destroy nerve cells and frequently damage small blood vessels supplying the brain.

The amount of damage inflicted depends to a large extent upon the type of virus, age and certain physical factors. Dr. Albert B. Sabin, who developed the vaccine against one type of the disease for our troops serving in the Far East, said susceptibility to encephalitis may have something to do with heredity—whether or not the virus finds an inherent chemical combination that helps it multiply within a person's body. It is also possible, he said, that susceptibility may be greater because of a weakness or the presence of other disease germs in a particular person's nervous system.

There is much about encephalitis that is still unknown, although it has been getting attention from medical researchers since about 1930. For instance, while mosquitoes get most of the blame for spreading the disease, it may well be that other insects are also implicated—mites, lice, ticks, etc.

In the 1933 St. Louis epidemic chickens were found to be heavily infested with the virus. This has led to demonstrations that chicken mites could well have been responsible for helping spread the infection. Laboratory experiments have shown that dog ticks can carry the disease also, but no parallel has been found in nature.

Just as important as determining what insects can transport encephalitis is finding the disease reservoir—the place where the insect picks up the virus. Birds, both wild and domestic, may be the chief source. The virus has been discovered in species ranging from song sparrows to turkeys.

It is significant that the dozen or so breeds of mosquitoes known to be able to transmit encephalitis like to feed on this feathered population. Also, the fact that encephalitis fails to produce any severe symptoms among birds indicates that they and the virus may have become adaptable to each other.

Birds may not be the only natural reservoir, however. Evidence of the virus has also been found in domestic farm animals, rodents and other forms of wild life. It's even possible that sometimes the disease may be directly transferred from one human to another by the mosquito, as is the case in malaria. This mode of transmission is probably rare, if it actually does occur. The animal to human route appears to be more usual.

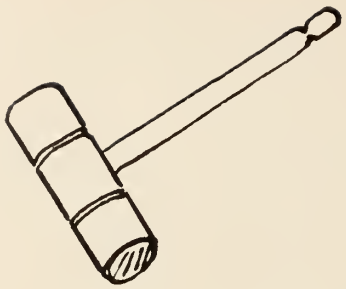
From what is known about encephalitis, it appears that it cannot be stamped out by eradicating one form of insect, as malaria has been virtually eliminated in this country by killing off a certain breed of mosquito.

Encephalitis is basically a disease of small animals. In this sub-human world it thrives and is probably passed from one species to another by a variety of infesting insects. Once in a while an insect comes along that will bite both animal and man. Then given the right circumstances—a large reservoir of infected birds, a large mosquito population and a dense human population, for instance—and you have an epidemic.

Perhaps the only sure way of eliminating encephalitis would be to kill off much of the animal population, including valuable domestic breeds, or to wipe out insect life—an impossible task.

"More realistic," said Dr. White, "would be a nationwide program of surveillance. By keeping close watch on encephalitis in animals, by taking into account the density of insect populations as well as the predominant variety in any one area, it may be possible to initiate a program of encephalitis prediction, as influenza epidemics are now predicted.

"Once it is possible to predict where and when encephalitis might strike, then it would also become possible to take strong, concentrated control measures to make sure that the disease doesn't 'accidentally' get transmitted to man."



President's Page



At the time of this writing HR 11865, the Social Security Amendments Bill reported out by the House Ways and Means Committee, has been considered by the Senate Finance Committee of which Senator Harry F. Byrd of Virginia is chairman. As is well known, Social Security for physicians and interns was added to the Social Security Amendments of 1964 which was passed by the House by a vote of 388 to 8. The Medicare portion of this controversial bill was left out by the House Ways and Means Committee and by the Senate Finance Committee, a five per cent increase in Social Security "dole" being added. The Medicare feature of the bill was not reported out by the Senate Finance Committee but either one of four Senators, Gore, Javits, Ribicoff, or Humphrey was expected to "tack it on" to HR 11865. Placing physicians and interns under Social Security was deleted from the Senate Finance Committee report by a vote of 14 to 1.

This being an election year any popular move that might prove politically helpful in November is being considered for passage for political reasons. American Medicine is being sacrificed on the altar of political expediency. We can only hope that the mechanical procedures necessary to go through with to enact legislation will be enough protection against socialization at this time. Even though the Medicare Amendment (compulsory health insurance) might have been thoroughly blocked by going back to

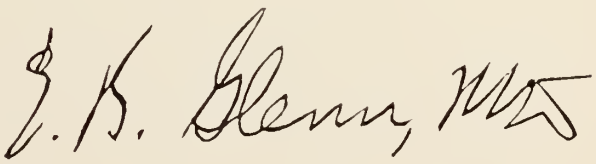
Congressman Mills' House Ways and Means Committee, other attempts to open the door to socialized medicine now are evident. In order "to establish the principle of social insurance medicine," Senator Jacob Javits (R., N. Y.) would add "up to 45 days hospitalization and up to 180 days of nursing home care financed through social security taxation."

Our two Senators, Lister Hill and John Sparkman, were visited personally in Washington by a delegation from Alabama representing MASA. Two physicians, Dr. John Chenault and Dr. M. Vaun Adams, were accompanied by Mr. Charles Weston, President of Barbour County Farm Bureau, Judge Newton Powell, Circuit Court Judge, Morgan County, and State Senator John Tyson, Mobile. They were most cordially received and information was obtained regarding the procedures that would be followed in handling HR 11865 once it was reported out of the Senate Finance Committee. The AMA asked us to proceed with our last minute letter writing and a letter was sent out from the Central Office to the entire membership asking that Senators Hill and Sparkman be contacted by letter urging opposition to the Medicare Amendment.

Let us be reminded of the situation in England with the National Health Service. A personal note dated August 4, 1964 from an American physician who is a relative and is in England now states: "It is quite obvious the people like the National Health Service and I am sure nothing could persuade them to go back to the old system of private practice. And as far as I can see the doctors who work for NHS have no say any more over what their fees are to be or what the hospital facilities are to be—These are now decided by the politicians"—"if American medicine does not want socialization they 'better never' give it a foothold."—"The public loves it and the doctors haven't a chance except to leave the country, which they are doing at the rate of 400 per year!"—"The local general practitioner gets a pretty tough deal."

Let us hope that an impasse in legislation has developed and that HR 11865 has nothing detrimental to medicine in it when the final version is passed.

Elsewhere in this *Journal* is an article regarding medical reports to the Disability Determination Unit of the Vocational Rehabilitation Service. This, of course, is dealing with Social Security claims for total disability. Since Social Security can never be done away with, the doctors need to control the misuse of claims by reporting as accurately as possible.



E. B. Glenn, M. D.

A Symbol
to Support...

AMA-ERF

American Medical
Association — Education
and Research Foundation
535 N. Dearborn St., Chicago 10, Ill.

ORGANIZATION SECTION

SOCIAL SECURITY DISABILITY BENEFITS

E. B. Glenn, M. D.

Recently my attention has been called to the fact that Alabama physicians are providing approximately 25,000 reports a year on behalf of patients applying for social security disability benefits. The total number of reports turned in on a national level numbers approximately one million. This represents the number of people on social security who feel that they are totally disabled and are asking private physicians to support their contentions by filling out the forms for them. This means that they would receive disability payments prior to the retirement age of 65 in the case of men and age 62 in the case of women.

In order to keep this reporting in the hands of the practicing physicians, the patient must get the information from an attending physician. When the form is completed a board of physicians (who, incidentally, are members of the State Medical Association) are employed to review these cases. Approximately twice as many claims are allowed as are disallowed (1,800,400 allowances or 66% as against 934,900 denials or 34% cumulative through September, 1963).

Alabama has been requested to take part in a two-fold experiment, first, to ease the task of reporting for the attending physician and, second, to expedite the process of gathering medical evidence. A new medical report record has been devised and a new method of obtaining supplementary evidence from attending physicians is being put into effect.

Physicians have been consulted throughout the country in devising the new report record. It provides adequate space for recording history and physical findings, laboratory data and other information that will facilitate the evaluating physician in determining the merits of the case. Copies of private physicians' records or reports on their own stationery may still be sent.

In addition to this information, should the doctor who reviews the case need additional reports such as EKG, X-ray, or laboratory studies, he **may** request the attending physician to do this work provided the attending physician has the facilities available. Payment for this can be authorized by the evaluating physician if he feels that this information is needed to more clearly evaluate the case. This will serve to avoid the necessity of employing a consultant which is sometimes necessary.

This new method now seems to give the attending physician more say-so in determining whether a patient should receive disability or not. The members of the evaluating board never see the patient and must rely on the information received on the forms submitted by the patient, attending physician, and any hospital records that might be available.

This law has been in effect since 1955. Responsibility is placed on physicians to see that it is administered fairly and those who deserve disability receive it and those who do not deserve consideration are kept from receiving it. By having more complete reports submitted fewer unnecessary claims will be presented. If the medical profession can see its way clear to accept this responsibility then it will not be necessary to have the Government "step in and take over." When physicians do not accept problems of administration where the law requires it then a federal agency is bound to take over.

around the state



Steve Yates



Michael Cram

NEWS FROM J. C. M. S.

Michael Cram, assistant executive secretary of the Jefferson County Medical Society, has been appointed acting executive secretary, succeeding Steve Yates who resigned to accept a position at the University of South Florida in Tampa.

Mr. Cram is a graduate of Birmingham-Southern College where he majored in journalism and speech. He joined JCMS in 1962.

Mr. Yates, a Florida native, will be assistant professor in the English department. In addition to teaching journalism, he will serve as advisor to the campus newspaper.

Mr. Yates helped the Jefferson County Medical Society establish its first executive office and has served as executive secretary since February, 1956.

MOUND PARK HOSPITAL FOUNDATION, INC.

701 Sixth Street South
St. Petersburg, Florida
33701

Symposium on MODERN CONCEPTS OF NUTRITION AND HEART DISEASE, American Medical Association, Mound Park Hospital Foundation, Department of Medical Education of the Mound Park Hospital, Medical and Research Divisions of Bay Pines V. A. Center, Pinellas County Medical Society, American Academy of General Practice—October 22 to 24, 1964, inclusive. The Foundation reserves the right to limit registration. Fee $15.00 (by special arrangement). 18 Credit Hours Category 1 allowed. Address NUTRITION, Mound Park Hospital Foundation, Inc., St. Petersburg, Florida, 33701.

ALABAMA DIABETES ASSOCIATION

Alabama physicians are invited to hear three nationally-regarded speakers at a meeting of the Alabama Diabetes Association in Birmingham September 13 preceding the Seventh Annual Medical Progress Assembly.

The Diabetes Association will meet from 1 P. M. to 5 P. M., at the Parliament House.

Speakers will be:

Dr. Stuart Soeldner, research assistant, New England Deaconess Hospital, assistant in medicine at Peter Bent Brigham Hospital and associate of the Baker Clinical Research Laboratory, on "Pre-Diabetes."

Dr. Max Ellenberg, chief of the diagnostic center at Mt. Sinai, New York, Hospital, president of the New York Diabetes Association, co-author of the book, *Clinical Diabetes Mellitus*, and author of more than 40 articles, on "Diabetes Neuropathy."

Dr. Victor E. Pollak, research associate professor of medicine, University of Illinois College of Medicine, assistant attending physician, Presbyterian-St. Luke's Hospital, Chicago, and editor of the *Year Book of Cardiovascular and Renal Diseases*, on "Renal Disease in Diabetes."

Further information may be obtained from Dr. Buris R. Boshell, University of Alabama Medical Center, Birmingham.

WILLIAM C. FLEMING, M. D.

William C. Fleming, M. D., has been appointed Physiatrist-in-Chief, Physical Medicine and Rehabilitation Service, University of Alabama Hospitals and Clinics, and Medical Director, The Spain Rehabilitation Center. Dr. Fleming is also Professor and Chairman, Department of Physical Medicine and Rehabilitation, Medical College of Alabama. The appointment was announced jointly by Joseph F. Volker, D. D. S., Ph. D., Vice-President for Health Affairs; Matthew F. McNulty, Jr., General Director, University of Alabama Hospitals and S. Richardson Hill, Jr., M. D., Dean, Medical College of Alabama.

In his new duties, Dr. Fleming will be responsible for the clinical coordination and supervision of patients in the Rehabilitation Center and patients in the sphere of Physical Medicine and Rehabilitation in the University Hospital. In addition, he will be responsible for coordination of the Physical Medicine Department at the University Hospital.

Formerly Assistant Professor of Physical Medicine at the University of Miami School of Medicine and Chief of the Physical Medicine and Rehabilitation Service at the Veterans Administration Hospital, Coral Gables, Florida, Dr. Fleming received his medical degree from the University of Virginia, Charlottesville in 1945, and took postgraduate training at the Medical College of Virginia and McGuire Veterans Administration Hospital in Richmond from 1953 to 1956.

Dr. Fleming was certified by the American Board of Physical Medicine in 1958. He is a member of the American Congress of Physical Medicine and Rehabilitation and the American Academy of Physical Medicine and Rehabilitation. He is also secretary of the Section on Physical Medicine of the Southern Medical Association.

In commenting on the appointment, Mr. McNulty said "The Medical Center is fortunate in having secured the services of a physician whose experience, qualifications and earned recognition in his field eminently qualify him in his new responsibilities in the University of Alabama Hospitals and the Medical College.

"Under Dr. Fleming's medical leadership, The Spain Rehabilitation Center should grow and develop into one of the outstanding centers in the country."

Alabama Department of Public Health



Dr. Ira L. Myers

Alabama Water Improvement Commission Responsibilities, Activities and Accomplishments

Ira L. Myers, M. D., State Health Officer
Chairman, Water Improvement Commission

Air, water, and food are essentials of life and must be available in a usable state to maintain health. Pollution or contamination of any of these essentials endangers life. The Water Improvement Commission is the water pollution control agency in this state.

Alabama is blessed with abundant ground and surface water replenished by an average annual rainfall varying geographically from 48 to 64 inches. There are 1,700 miles of "navigable" rivers with a greater aggregate length of tributaries, 400,000 acres of man-made lakes, many natural lakes, and more than 20,000 artificial ponds totaling more than 80,000 acres.

From surface sources, municipal water systems draw 200 million gallons daily, industry uses 600 million gallons, and 4,000 million gallons per day are required for power plants.

History of Water Pollution Control Legislation in Alabama

A number of conferences held in 1946 and 1947 resulted in the enactment of a legislative bill which was acceptable to the participants who represented industry, wildlife, and the affected state agencies. Following its passage, this bill was signed by the Governor on September 30, 1947. The Act created a commis-

sion without any regulatory authority to study and report on water quality conditions within the state. By 1949, determinations of physical, chemical, biochemical, and bacteriological characteristics of all surface waters in the state had been made. This report was submitted to the 1949 Legislature together with recommendations for amendments to the act which would give the Commission regulatory authority.

The amendments of 1949 gave the Commission control of new sources of pollution discharged after August 25, 1949. The Commission was likewise authorized to control pollution of all sources which create health hazards. In 1963, the Commission joined the efforts of wildlife and related agencies who have tried unsuccessfully for the past ten years to remove the "grandfather" clause of this law. This "grandfather" clause excludes wastes discharged prior to August 25, 1949, from control if they are not hazards to health.

The Water Improvement Commission, Its Objectives And Programs

The Commission is solely responsible for water pollution control in Alabama. The Commission and State Department of Conservation co-operate in the investigation of situations resulting in fish kills and other matters in which each may have an interest. Others assisting the Commission in its activities include the State Oil and Gas Board, Alabama Geological Survey, and United States Geological Survey.

The purpose of Alabama's water pollution control law is defined in the following manner: "The improvement and conservation of the ground and surface waters of the State of Alabama is of utmost importance. The existing water conditions of the state and right of municipalities, industries and individuals to the reasonable use of such waters so as to promote the continued growth and development of the state, in industry, agriculture, health and conservation of natural resources are recognized."

The objectives of the Commission are to regulate and control the discharge of wastes of a pollutional character in a manner commensurate with the expressed purpose of the water pollution control law. The Commission seeks voluntary compliance on the part of those exempt from the provisions of the law. In its approach to the problem of waste control, the Commission considers each waste discharge on its own merits and on the basis of established and foreseeable use of the receiving waters. While the Commission has not felt that state-wide classification of waters for the purpose of waste control is the best approach, it does apply recognized standards of water quality to waste discharges under its jurisdiction as necessary to protect the quality of receiving waters.

In the matter of new or increased sources of wastes, the Commission sets conditions under which these discharges will be permitted and refuses to issue waste discharge permits until it is assured that its requirements will be met. The conference approach has been relied upon in handling existing sources of waste subject to the Commission's authority. While this approach is in some instances time-consuming, it has been highly successful in most cases and certainly more acceptable to the parties concerned than legal action. It is a well-known fact that legal action can involve months and even years of litigation during which staff members assigned to the case must give it undivided attention.

Within the limits of its financial resources, the Commission sponsors investigations and studies either leading to improvements in water pollution control or supplementing the Commission's consideration of specific problems.

Note: This is the first of three articles about the Water Improvement Commission. The article next month discusses Federal and State roles in water pollution control and points out water quality conditions in Alabama. The final article summarizes the status of pollution control in Alabama and offers approaches to more effective water pollution control.

BUREAU OF LABORATORIES

Thomas S. Hosty, Ph.D., Director

July 1964

Examinations for intestinal parasites	1,216
Typhoid cultures (blood, feces, urine and other)	264
Brucella cultures	2
Examinations for malaria	8
Examinations for gonococci	1,842
Serologic tests for syphilis (blood and spinal fluid)	24,219
Darkfield examinations	5
Agglutination Tests	1
Examinations for diphtheria bacilli and Vincent's	24
Complement fixation tests	72
Examinations for Negri bodies (smears and animal inoculations)	248
Water examinations	3,255
Milk and dairy products examinations	3,825
Examinations for tubercle bacilli	3,558
Miscellaneous examinations	4,406
Total	42,945

BUREAU OF PREVENTABLE DISEASES

W. H. Y. Smith, M. D., Director

CURRENT MORBIDITY STATISTICS

1964

	June	July	*E. E. July
Tuberculosis	120	93	170
Syphilis	118	241	135
Gonorrhea	270	420	323
Chancroid	0	0	2
Typhoid fever	2	1	2
Undulant fever	0	0	1
Amebic dysentery	1	4	3
Scarlet fever & strep. throat	77	136	29
Diphtheria	0	1	1
Whooping cough	68	23	21
Meningitis	12	11	4
Tularemia	0	0	0
Tetanus	0	0	2
Poliomyelitis	0	0	7
Encephalitis	0	0	1
Smallpox	0	0	0
Measles	1,981	261	92
Chickenpox	73	10	16
Mumps	54	19	36
Infectious hepatitis	29	78	31
Typhus fever	1	1	0
Malaria	0	0	0
Cancer	1,018	771	627
Pellagra	2	0	0
Rheumatic fever	17	17	11
Rheumatic heart	27	11	20
Influenza	10	19	20
Pneumonia	226	187	114
Rabies—Human cases	1	0	0
Pos. animal heads	0	0	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

BUREAU OF VITAL STATISTICS

Ralph W. Roberts, M. S., Director

PROVISIONAL BIRTH AND DEATH STATISTICS AND COMPARATIVE DATA, JUNE 1964

Live Births / Deaths / Causes of Death	Number Registered During June 1964			Rates* (Annual Basis)		
	Total	White	Non-White	1964	1963	1962
Live Births	5,777	3,720	2,057	20.7	20.4	20.8
Deaths	2,615	1,743	872	9.4	8.7	8.4
Fetal Deaths	143	67	76	24.2	21.0	18.7
Infant Deaths—						
under one month	112	58	54	19.4	24.8	24.5
under one year	147	73	74	25.4	33.3	31.3
Maternal Deaths	4		4	6.8	8.7	8.6
Causes of Death						
Tuberculosis, 001-019	21	9	12	7.5	6.5	8.4
Syphilis, 020-029	4	1	3	1.4	1.1	2.9
Dysentery, 045-048					0.4	1.1
Diphtheria, 055						
Whooping cough, 056						
Meningococcal infections, 057	2	2		0.7		
Poliomyelitis, 080, 081	1	1		0.4	0.4	0.4
Measles, 085	5	3	2	1.8	0.4	
Malignant neoplasms, 140-205	347	259	88	124.3	117.6	114.4
Diabetes mellitus, 260	32	21	11	11.5	13.0	12.0
Pellagra, 281						
Vascular lesions of central nervous system, 330-334	413	253	160	148.0	122.7	115.5
Rheumatic fever, 400-402					1.4	0.7
Diseases of the heart, 410-443	893	639	253	320.0	295.5	281.3
Hypertension with heart disease, 440-443	123	44	79	44.1	48.7	41.2
Diseases of the arteries, 450-456	60	44	16	21.5	18.8	16.8
Influenza, 480-483	2	1	1	0.7	2.2	2.9
Pneumonia, all forms 490-493	54	36	18	19.3	23.1	15.3
Bronchitis, 500-502	3	3		1.1	1.4	0.4
Appendicitis, 550-553	3	2	1	1.1	1.1	0.7
Intestinal obstruction and hernia, 560, 561, 570	17	12	5	6.1	3.2	5.8
Gastro-enteritis and colitis, under 2, 571.0, 764	3		3	1.1	2.5	3.6
Cirrhosis of liver, 581	14	11	3	5.0	6.5	1.8
Diseases of pregnancy and childbirth, 640-689	4		4	6.8	8.7	8.6
Congenital malformations, 750-759	22	13	9	3.8	5.5	6.3
Immaturity at birth, 774-776	30	11	19	5.2	8.7	8.9
Accidents, total, 800-962	182	133	49	65.2	57.0	63.4
Motor vehicle accidents, 810-835, 960	92	75	17	33.0	29.2	29.5
All other defined causes	376	237	139	134.7	131.0	122.1
Ill-defined and unknown causes, 780-793, 795	127	51	76	45.5	38.2	37.5

*Rates: Birth and death—per 1,000 population
Infant deaths—per 1,000 live births
Fetal deaths—per 1,000 deliveries
Maternal deaths—per 10,000 deliveries
Deaths from specified causes—per 100,000 population

The Woman's Auxiliary



Dear Doctors:

When you read this, the children will all be back in school and I hope your wife is busy, not only with the P. T. A., but, with her Medical Auxiliary plans for the coming year. This is August and I am sitting at my typewriter here on Smith Lake with our eight year old son, Hank, waiting to go skiing.

I have been reviewing the mail I have received and my notes and memories of the convention in San Francisco. Several of my friends over the state have written asking what we were going to emphasize this year. A project, to be successful, needs to fill a local need. I can think in terms of Cullman County because that is where we live, but the needs of all the counties North, South, East, and West of us you know because that is where you live.

Have a committee meeting of two with your wife, she will enjoy talking to you between telephone calls, and discuss your local needs in Health Career Recruitment, Disaster Preparedness, Rural Health, Community Service, Safety, Mental Health, and politics. Colorado reported on a county project that was a sort of combination mental health and community service affair, a rehabilitation course and introduction to the outside world for convicts about to be released. During the question and answer period afterwards, one of the "Girls" asked how you could tell a graduate of this course. The Colorado president thought a little bit and said, "I don't know, unless they said, 'Stick 'em up, please.'" Of course, this project might not appeal to the Montgomery Auxiliary.

Statewide, encourage your wife to raise money for AMA-ERF. Dr. Hill, the Dean of our medical school, appreciates and needs the money. It helps to release his bondage to the federal government. I feel that every doctor's wife should be a member of your local mental health organization. You may be too busy to attend the meetings and this group needs informed members who can explain intelligently, organized medicine's position to this group's membership. It might have saved us some trouble last year.

Nationally, we increased our dues $1.00 in San Francisco. This will make it possible for every Auxiliary member to receive the *Bulletin* as a part of her national dues. The *Bulletin* has a new format and makes very interesting reading. Examine one of her copies. I believe you will think it worthwhile. The AMA is picking up the tab this year in order to give the state auxiliaries time to raise their dues and change their by-laws.

I'm real proud of us nationally. Mrs. John M. (Belle) Chenault was elected a national director for the next two years. When Belle gets all of her little children raised, I believe we will have another National President to join Louise, Mrs. William G. Thuss, Sr., in those ranks. Mrs. W. R. (Marlys) Sutton, last year's state president, has been appointed Southern Regional Mental Health Chairman. The National Safety Council presented us with a Certificate of Commendation for work in accident prevention.

Pat your fellow committee member on the back. Her hard work made possible all of this national recognition and don't forget your committee meeting.

Sincerely,

Frances Clemmons

P. S. Remember to save your drug samples for International Health.



The Doctor's Visit, Jan Steen 1626-1679, Mauritshuis, The Hague

In Diverticulosis and Diverticulitis...

METAMUCIL® brand of psyllium hydrophilic mucilloid

"Diverticulosis ... a low-roughage diet is advisable.... Constipation is avoided, preferably by the daily use of Metamucil.

"Diverticulitis Mild, chronic symptoms of diverticulitis, such as diarrhea or flatulence also are treated[1] by low-roughage diet, adequate fluid intake and Metamucil...."

Usual Adult Dosage: One rounded teaspoonful of Metamucil (or one packet of Instant Mix Metamucil) in a glass of cool liquid one to three times daily.

Metamucil is available as Metamucil powder in containers of 4, 8 and 16 ounces and as flavored Instant Mix Metamucil in cartons containing 16 and 30 single-dose packets.

1. Welch, C. E., Diverticula of the Alimentary Tract, in Conn, H. (editor): Current Therapy—1961, Philadelphia, W. B. Saunders Company, 1961, pp. 224-225.

SEARLE

Research in the Service of Medicine

"If food makes him feel good, it is not at all surprising that he will turn to it when times are tough, and his tension mounts."[1]



ESKATROL® Trademark

Each capsule contains Dexedrine® (brand of dextroamphetamine sulfate), 15 mg., and Compazine® (brand of prochlorperazine), 7.5 mg., as the maleate.

SPANSULE®

brand of sustained release capsules

controls appetite all day long with a single morning dose

relieves the emotional stress that causes overeating

Brief Summary of Principal Side Effects, Cautions and Contraindications

Side effects (chiefly nervousness and insomnia) are infrequent, and usually mild and transitory.

Cautions: 'Eskatrol' *Spansule* capsules should be used with caution in the presence of severe hypertension, advanced cardiovascular disease, or extreme excitability. There is a possibility, though little likelihood, of blood or liver toxicity or neuromuscular reactions (extrapyramidal symptoms) from the phenothiazine component in 'Eskatrol' *Spansule* capsules.

Contraindications: Hyperexcitability, hyperthyroidism.

Before prescribing, see SK&F Product Prescribing Information.

Supplied: Bottles of 50 capsules.

1. Dorfman, W., and Johnson, D.: *Overweight Is Curable*, New York, The Macmillan Company, 1948, p. 16.

Smith Kline & French Laboratories SK&F



"Wonderful...haven't had opening in both nostrils for years"*

(clearly decongested with Dimetapp)

Dimetapp lets your "stuffed-up" patients *breathe easy again.* Each long-acting Extentab works hard for up to 10-12 hours clearing away stuffiness, turning off the drip, and unplugging congestion that accompanies upper respiratory conditions. Yet, patients seldom experience drowsiness or overstimulation. (A key to success: the Dimetapp formula.) Now that the "stuffy" season is here, keep dependable Dimetapp Extentabs on tap. They get the job done.

FOR NASAL DECONGESTION IN SINUSITIS, COLDS, U.R.I.

UP TO 10-12 HOURS' CLEAR BREATHING ON ONE TABLET

Dimetapp® Extentabs®

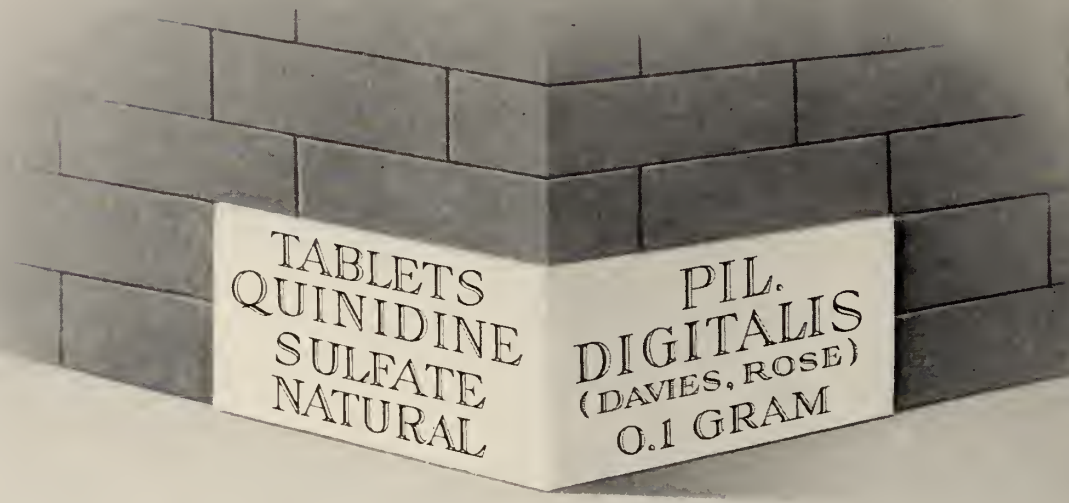
(Dimetane® [brompheniramine maleate], 12 mg.; Phenylephrine HCl, 15 mg.; Phenylpropanolamine HCl, 15 mg.)

BRIEF SUMMARY: Indications: Dimetapp reduces nasal secretions, congestion, and postnasal drip for symptomatic relief of colds, U.R.I., sinusitis, and rhinitis. **Side Effects:** In high dosages, occasional drowsiness due to the antihistamine or CNS stimulation due to the sympathomimetics may be observed. **Precautions:** Administer with caution in the presence of cardiac or peripheral vascular diseases and hypertension. **Contraindications:** Antihistamine sensitivity. Not recommended for use during pregnancy.

*Clinical report on file, Medical Department, A. H. Robins Co., Inc.

A. H. ROBINS CO., INC., RICHMOND 20, VA.

A CORNERSTONE OF CARDIAC THERAPY



The Dictionary defines a cornerstone as something of fundamental importance, just as Pil. Digitalis, (Davies, Rose) and Tablets Quinidine Sulfate Natural (Davies, Rose) are of fundamental importance in treating your cardiac patients. These preparations represent 60 years of experience and dependability in the manufacture of pharmaceuticals.

Pil. Digitalis (Davies, Rose), 0.1 Gram (approx. 1½ grains) which comprise the entire properties of the leaf, provide a dependable and effective means of digitalizing the cardiac patient, and of maintaining the necessary saturation.

Tablets Quinidine Sulfate Natural, 0.2 Gram (approx. 3 grains) are alkaloidally assayed and standardized, insuring uniformity and therapeutic dependability. Each tablet is scored for the convenient administration of half dosages.

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DQ-2



Outwardly calm...but what goes on inside?

Appearances on the outside do not necessarily suggest what goes on inside. This is particularly true of the ulcer patient, who may appear jolly and unruffled to his neighbors, but presents to you the classic symptoms: organic and functional disorders of the G.I. tract, associated with anxiety and tension.

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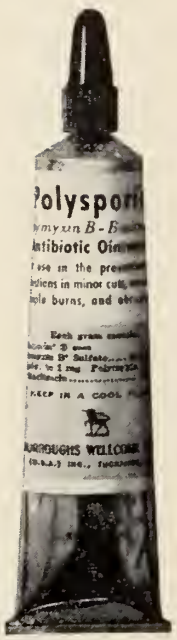
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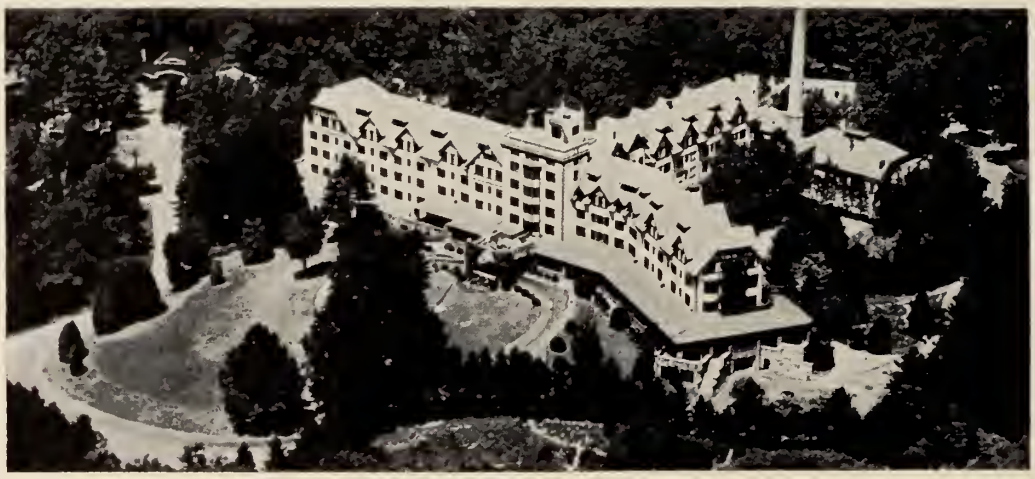
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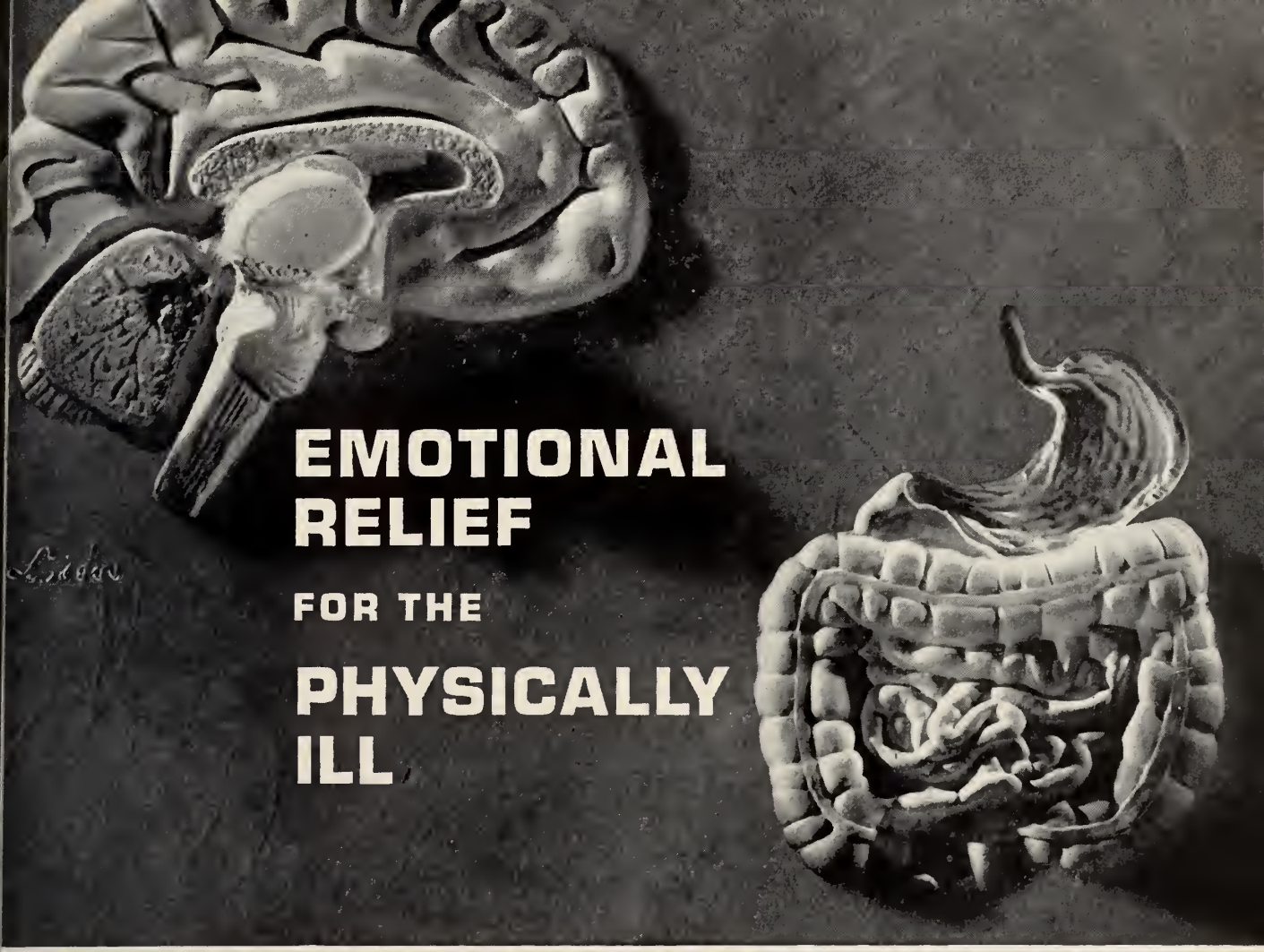
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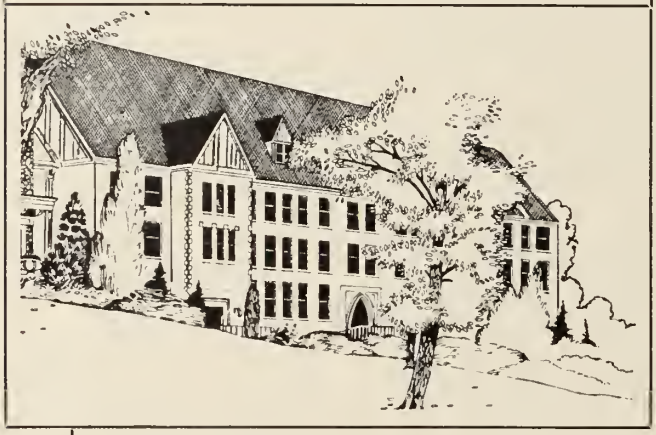
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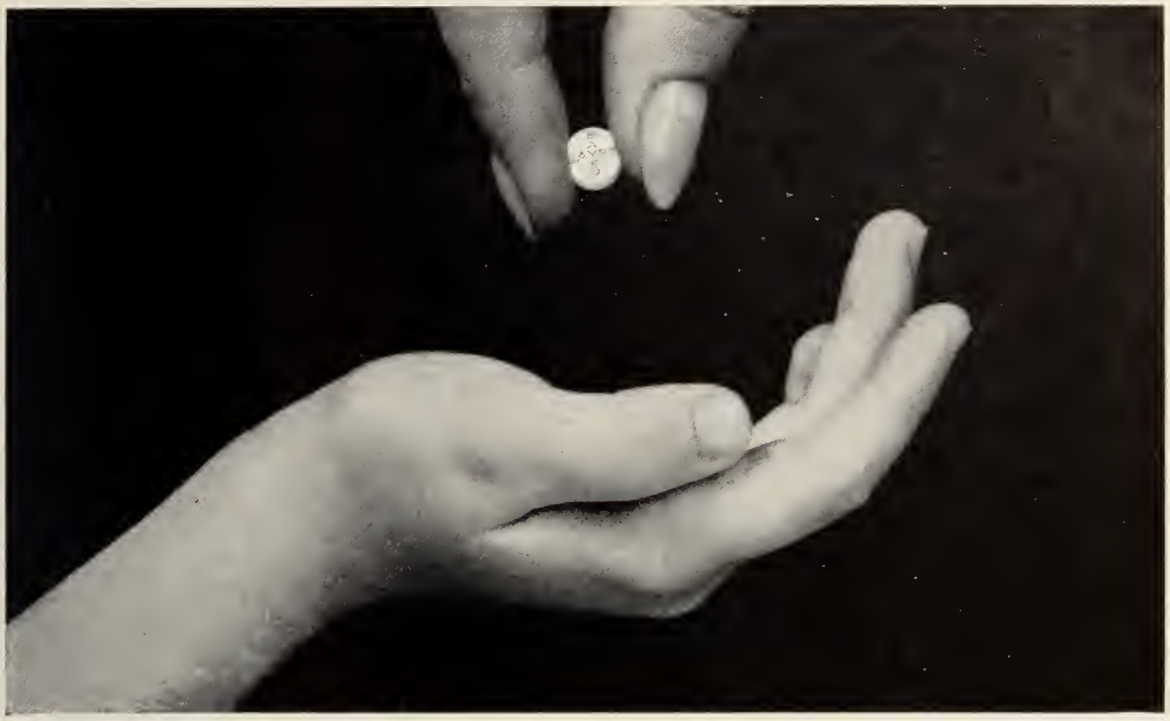
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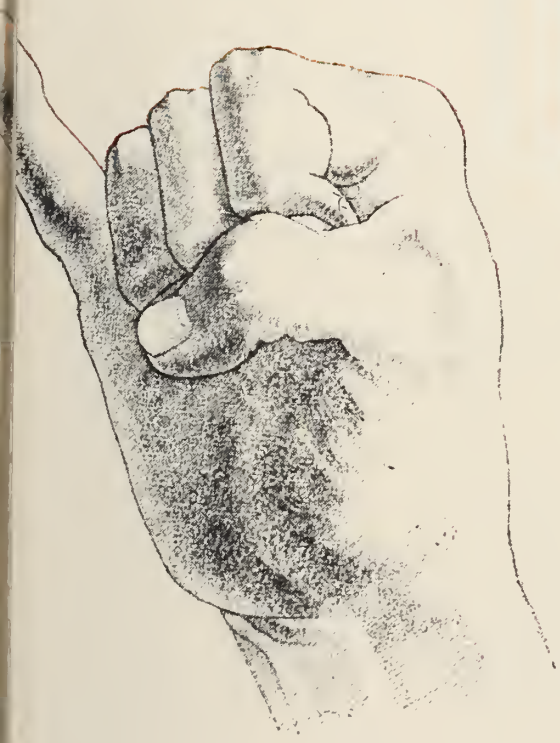
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s with any drug containing prednisone, Arthral-n-PR is contraindicated, or should be adminis-tered only with care, to patients with peptic ulcer, tuberculosis, nephritis, diabetes mellitus, acute psychoses, Cushing's syndrome (or Cushing's disease), overwhelming spreading (systemic) in-fection, or predisposition to thrombophlebitis.

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*Cohen, et al: J.A.M.A., 165:225, 1957.

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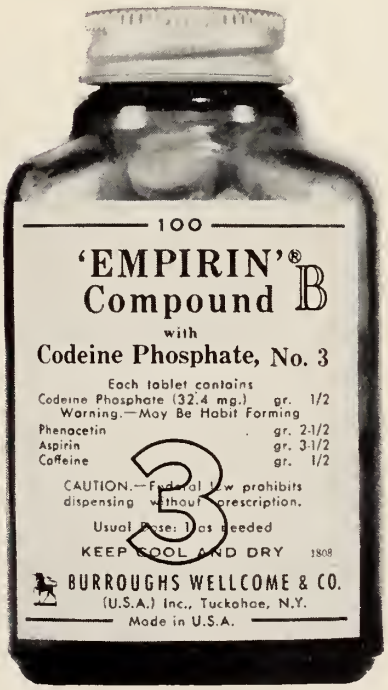
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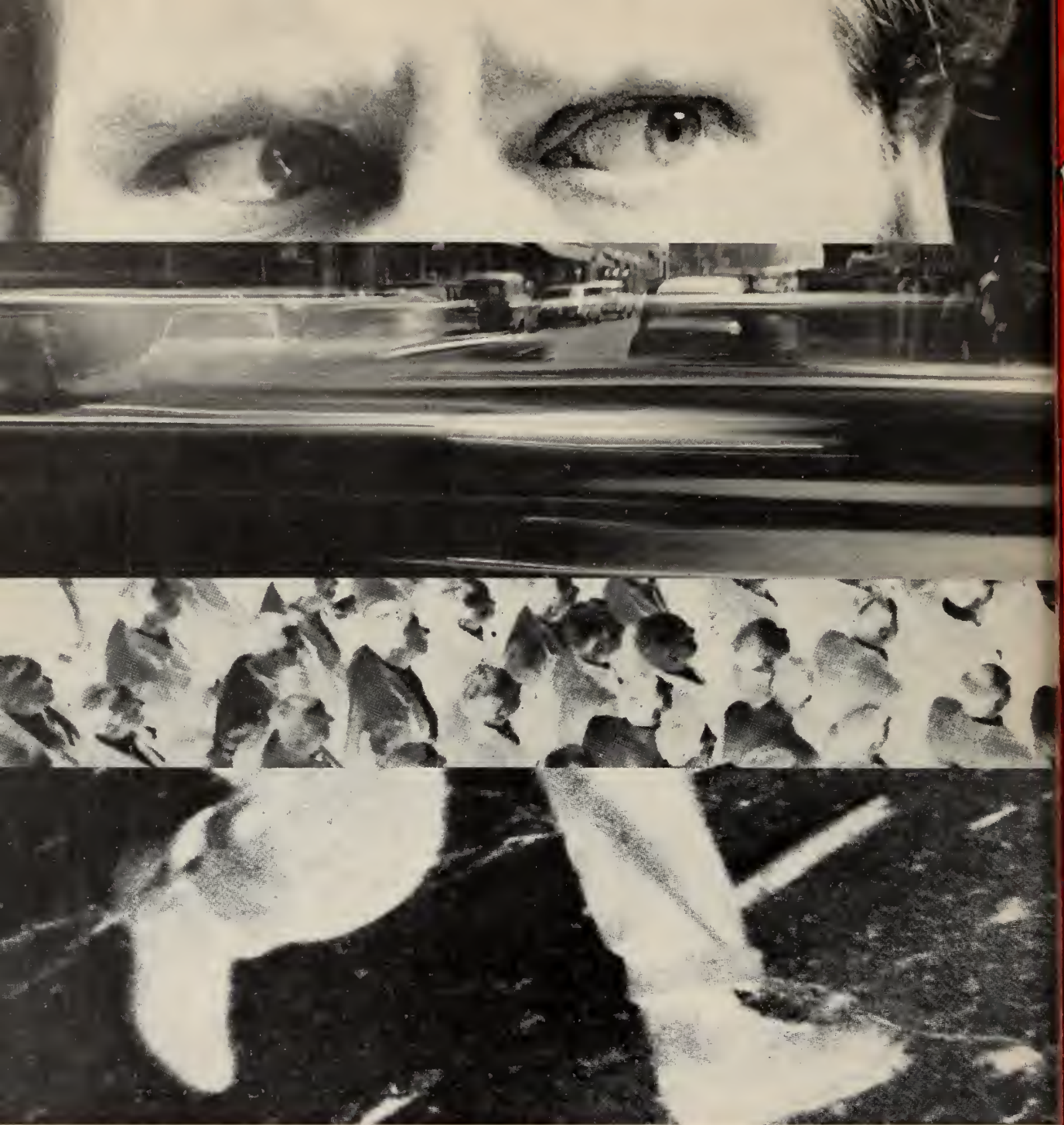
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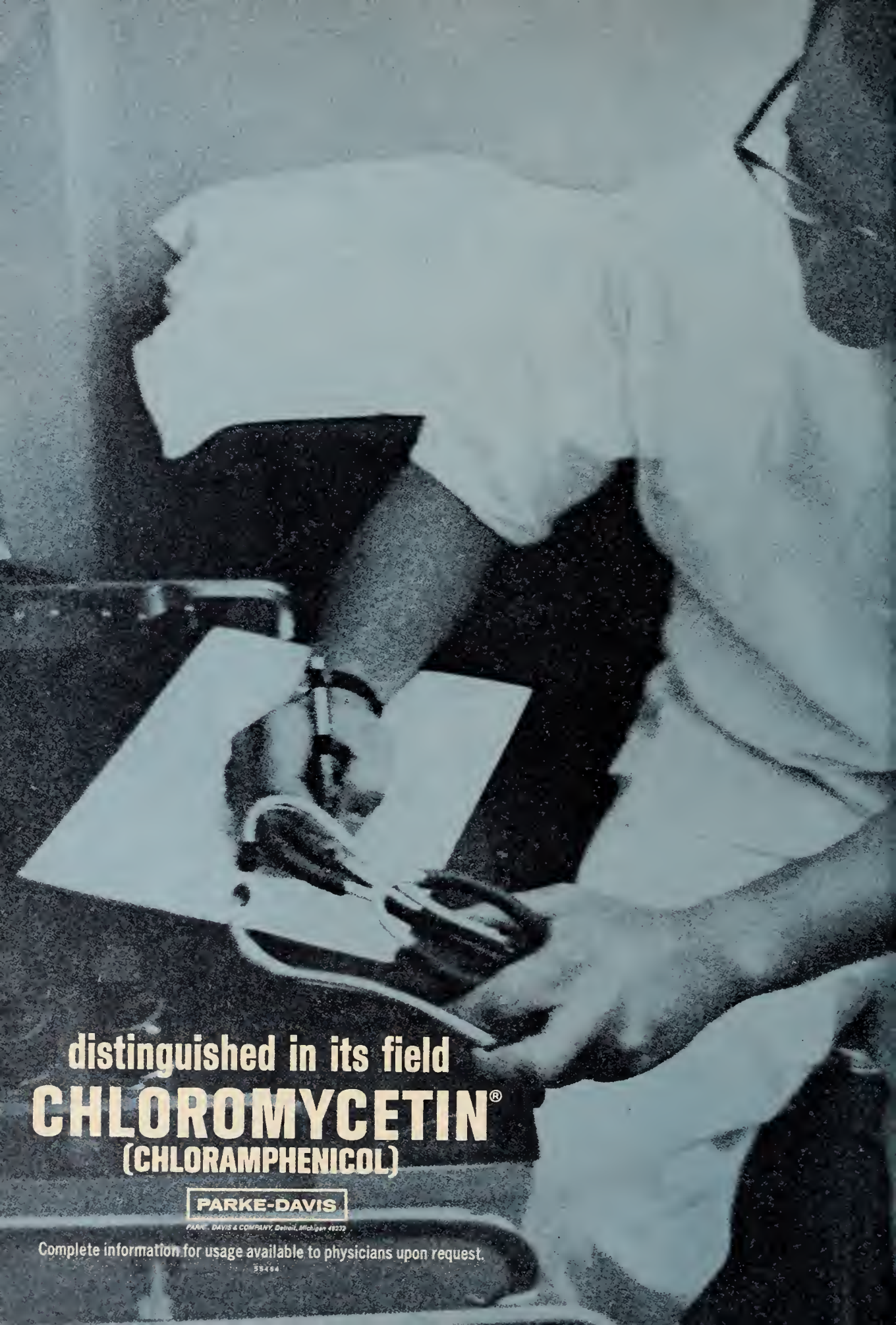
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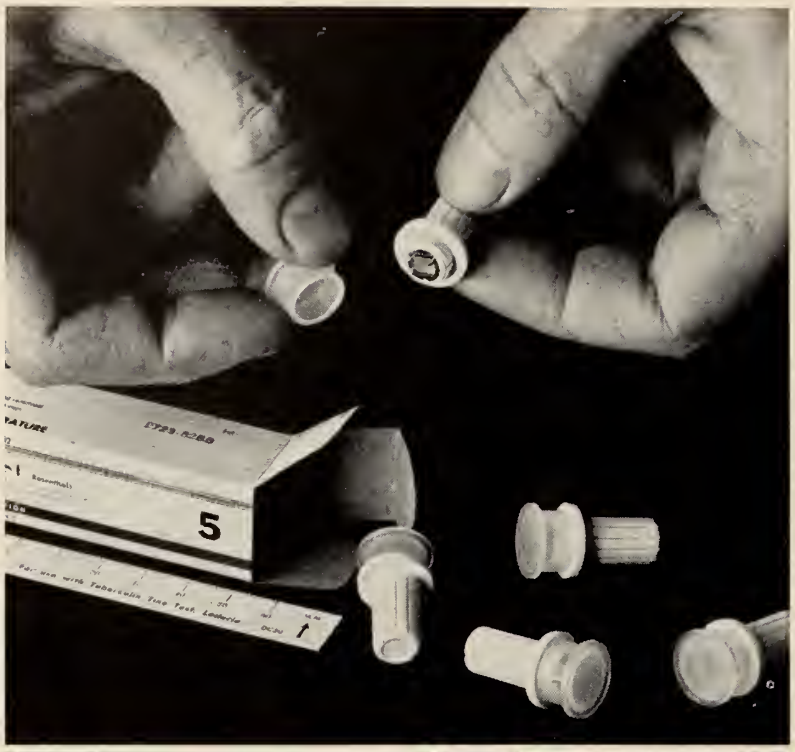
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*Hammerl, H.: Wien. Med. Wschr. 108:629, July 26, 1958.

Condition	No. of Patients	No. Cured with Signemycin
Abscess, pulmonary	17	16
Bronchiectasis	19	13
Bronchitis	286	267
Bronchopneumonia	192	179
Empyema	12	11
Pneumonia, lobar	150	146
Pneumonia, other febrile	160	150
Various infected pneumopathies	192	172
Totals	1,028	954 (92.8%)

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Chattas, A. et al.: Antibiot. Med. 7:300, May, 1960.

Condition	No. of Patients	No. Cured with Signemycin
Eye, ear, nose, throat infections	368	343
Respiratory infections	369	346
Gastrointestinal infections	42	30
Skin and soft-tissue infections	38	37
Deep-seated or generalized infections	47	44
Various conditions	157	150
Totals	1,021	950 (93.0%)

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SIGNEMYCIN®

Side Effects: Glossitis and allergic reactions, as well as severe anaphylactoid reactions, have been reported as rare side effects. Should significant reaction or idiosyncrasy occur, discontinue medication and institute countermeasures. Use of tetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. Reduce usual oral dosage and consider serum level determinations in patients with impaired renal function to prevent possible liver toxicity due to excessive accumulation of antibiotic in the serum.

Precautions: Overgrowth of nonsusceptible organisms may occur. In such cases, discontinue medication and institute appropriate specific therapy as indicated by susceptibility testing. Aluminum hydroxide gel given with antibiotics has been shown to decrease their absorption and is contraindicated. The coloring agents used in Signemycin Syrup and Pediatric Drops may produce red discoloration of stools.

Triacetyloleandomycin, a constituent of Signemycin, administered to adults in daily oral doses of 1.0 Gm. (3 Gm. Signemycin) for periods of more than ten days may produce hepatic dysfunction and jaundice. In the rare patient who requires this high dosage level of Signemycin initially, liver function should be carefully followed and dosage should be reduced, as promptly as possible, to the usual recommended range of 1.0 to 2.0 Gm. per day. Therefore, Signemycin is recommended primarily for the treatment of acute or severe infections, with treatment restricted to a ten-day period. If clinical judgment dictates continuation of therapy beyond ten days, serial monitoring of the liver profile should be carried out, including BSP, transaminase, and cephalin flocculation tests. Changes observed in liver function were reversible following discontinuation of the drug.

Formulas: Capsules: 250 mg. Signemycin (167 mg. tetracycline HCl and 83 mg. oleandomycin as triacetyloleandomycin).

Capsules: 125 mg. Signemycin (83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin).

Syrup: 125 mg. Signemycin (tetracycline equivalent to 83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin) per 5 cc.

Pediatric Drops: 100 mg. Signemycin (tetracycline equivalent to 67 mg. tetracycline HCl and 33 mg. oleandomycin as triacetyloleandomycin) per cc.

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Note:

The high rate of response to Signemycin in these cases is noteworthy because the totals include many patients with difficult-to-treat infections, many whose infections had proved resistant to other agents, and many who had been treatment failures on other therapy.[1-87] In addition the following criteria were used for the cases cited: (1) only published results were used (2) results were confirmed by clinical and/or laboratory findings (3) patients were cured, not "improved" (4) dosage conformed with current recommendations in the United States (5) no other anti-infective agents were used concomitantly (6) no instance of prophylactic use was included in these tabulations.

Condition	No. of Patients	No. Cured with Signemycin
Ear, nose and throat infections	507	465
Respiratory infections	1,028	954
Gastrointestinal infections	425	387
Genitourinary infections	748	684
Skin and soft-tissue infections	1,088	1,036
Bone and joint infections	71	64
Deep-seated or generalized infections	257	251
Obstetrical & gynecological infections	341	320
Miscellaneous conditions	592	570
Totals	5,057	4,731 (93.5%)

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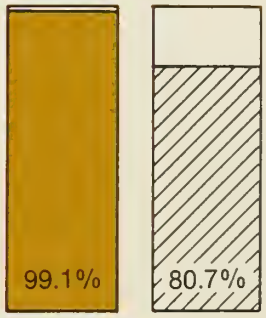
here are the facts on Safeguard's superior antibacterial effectiveness

The superior antibacterial action of Safeguard has been demonstrated by a variety of techniques. Below are some of the comparative results obtained with Safeguard ▬ and another leading deodorant and antibacterial bar soap containing 0.5% hexachlorophene and 0.5% 3,4,4'-trichlorocarbanilide. ▨

superior residual antibacterial effect proved by handwashing tests

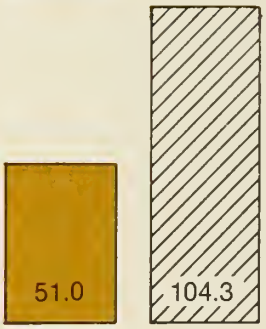
In a modified Price multiple washbasin procedure, Safeguard attained an average reduction of 99.1% in the number of organisms recoverable from the final rinse water, as compared to an average of 80.7% for the other antibacterial bar soap tested. Both products had been used exclusively for four days prior to evaluation.

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superior residual antibacterial effect confirmed by skin stripping technique

Safeguard and the other antibacterial bar soap were used for normal everyday toilet purposes by a group of housewives for 14 days. Layers of superficial skin cells were then taken by a stripping technique to determine the density of the bacterial population. The average count per 2.25 sq. cm. for Safeguard was 51.0 while the finding for the other antibacterial bar was 104.3—more than double Safeguard's reading.



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* Shaw, Jas. H., Caries-Producing Factors: a Decade of Dental Research, J. Am. Dent. A., 55:785 (Dec.) 1957.
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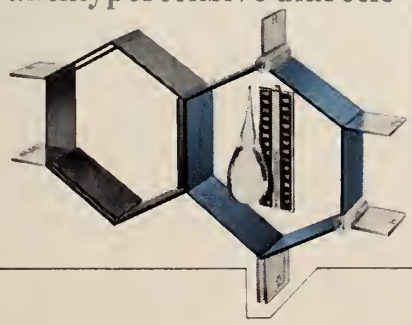
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CONTRAINDICATION: Anuria.

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Evaluation and Management of Chronic Renal Disease

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INTRODUCTION

The physician consulted for a specific complaint or for a routine physical examination arrives at an "impression" after pursuing leads supplied by a good history and physical examination. Quite frequently the diagnosis becomes obvious at this stage, however, in many situations, proper laboratory tests are essential for exact diagnosis. The latter is especially true of patients with renal disease; there is no **one** historical fact or physical finding that will alert the doctor to the presence of renal disease. Nor, is there any **one** laboratory procedure that is diagnostic. A logical, painstaking history followed by careful physical examination and supplemented by the appropriate renal function tests will usually enable the physician to arrive at the proper diagnosis.

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A. Facts In Patient's History Suggestive of Renal Disease

1. History of frequent urinary infections
2. History of nephritis or "Bright's Disease"
3. History of hypertension or edema
4. Family history of renal disease or hypertension
5. Retarded growth in a child or a history of bone disease
6. History of kidney stones
7. Symptoms referable to the GU tract, i.e., dysuria, frequency, incontinence, polyuria, nocturia. (The latter symptom, in terms of total nocturia volume, is most significant. Frequency is not as significant since it may be caused by obstructive phenonema, nervousness or insomnia. The average individual will void less than 300-500 cc of urine during the night; this will include all the

urine secreted from bedtime until complete emptying of the bladder on arising in the morning. Chronic renal disease will result in a marked increase in the volume of the night urine. However, it must be remembered that this may also be true in congestive cardiac failure, diabetes insipidus, polyuria for any reason, compulsive water drinking and hormonal dysfunction).

B. Physical Findings Suggestive of Renal Disease

1. Hypertension
2. Vasculitis as evidenced by ecchymosis, changes in the optic fundi, peripheral vascular abnormalities
3. Non-pitting edema—especially of face and eyelids
4. Palpably enlarged kidneys
5. Genito-Urinary abnormalities—C-V tenderness, lower GU tract findings (obstruction, inflammations, etc.)

C. Laboratory Tests For Renal Disease

1. *Urinalysis*—a normal casually voided specimen in a background suggestive of renal disease does not rule it out. Too often the urinalysis is relegated to the least intelligent or least skillful of the medical staff; this has engendered a casual attitude towards this very valuable examination. The urine may not only reflect changes due to intrinsic renal disease but also vascular disease, endocrine abnormality, various infectious, toxic and metabolic processes.

   The urine must be fresh, properly collected, scrupulously clean and the time of voiding noted. The specific gravity measurement, pH and microscopic examination are the parameters subject to greatest error. Changes in temperature, sugar or protein content affect the specific gravity. Urinometers must be standardized and calibrated. The presence or absence of bacterial contamination or infection can be determined by appropriate smears. Repeat examinations of the urine add tremendously to the significance of either positive or negative findings. Although quantitative study of urine sediment can be very instructive, in the great majority of clinical situations qualitative or semi-qualitative methods on random, clean-voided specimens of urine yield as much information as is necessary.

   Since the urinalysis must be interpreted in terms of renal dynamics, it will be discussed further under the section entitled, Renal Physiology.
2. *Renal function tests*—these will be discussed under Renal Physiology.
3. *Anatomical studies employing radio-opaque mediums,* i.e., pyelography, aortography, renal biopsy.

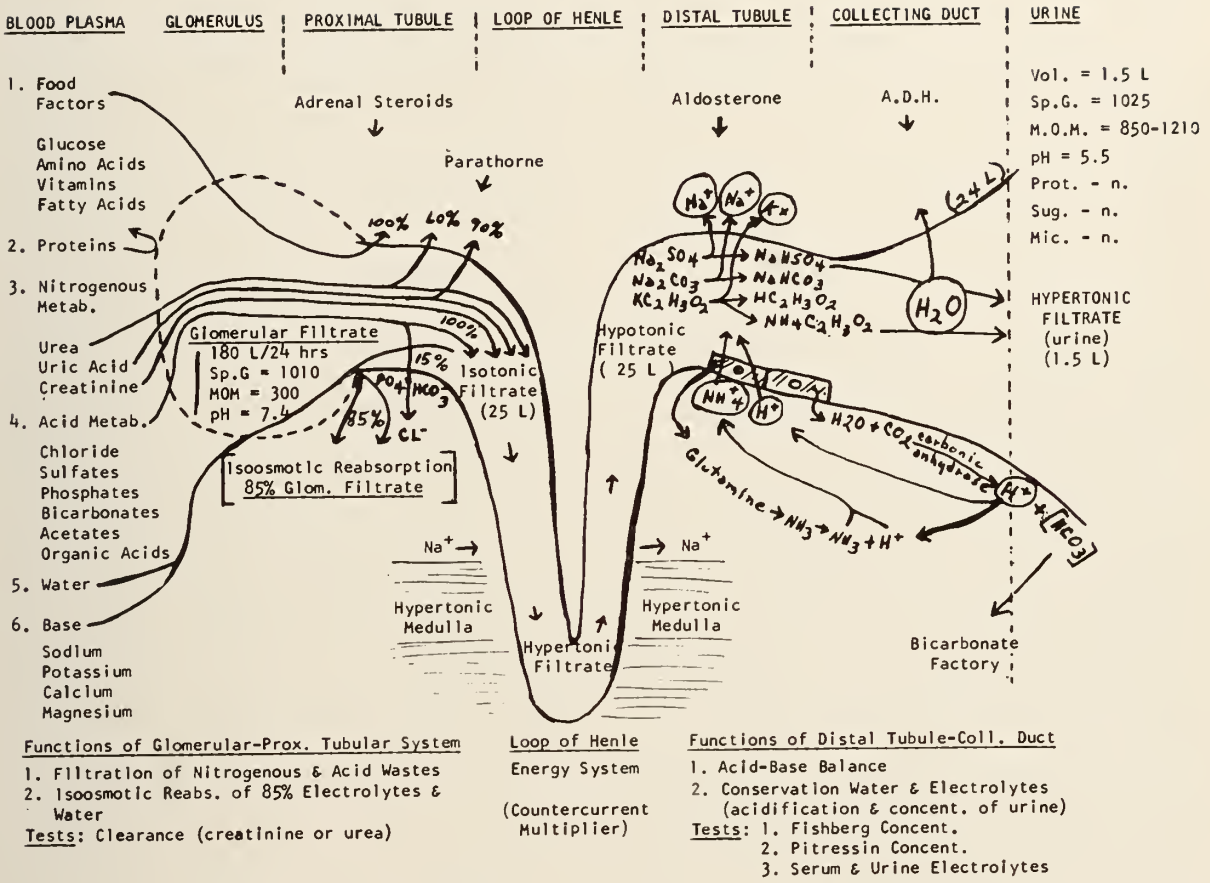
D. Renal Physiology

There is a tendency to approach the azotemic patient (with chronic renal disease) with pessimism; after all, totally destroyed nephrons cannot be replaced. However, with the aid of good physiological studies, the chronically azotemic patient can be maintained for many years in a sub-optimal homeostatic state by preventing super-imposed complications. This may be of special importance at this time since patients in chronic uremia can be kept alive for long periods of time by the use of artificial organ systems.

The prime function of the kidneys would appear to be the excretion of the toxic, acid products of metabolism without significant loss of water and base (salt) thus maintaining the normal extracellular fluid volume (blood volume) and acid-base balance. The normal kidney can perform this function easily because it can excrete urine of widely varying composition and volume; the latter is

Figure 1

Renal Physiology



influenced by body needs, diet and endocrine function. Anatomical segments of the nephron where the various functions are localized have been precisely determined. Moreover, knowing the specific pathological lesions of a disease, one can frequently predict the defects in electrolyte, water and acid-base balance in a given patient.

The kidneys can excrete a urine six times as dilute or four times as concentrated as the plasma in terms of its osmolarity. One hundred and eighty liters of glomerular filtrate that may contain 250,000 mEq. of sodium and 25 gms. of urea nitrogen may end up, in the space of 24 hours, in the excretion of one liter of urine containing 150 mEq. of sodium and 15 gms. of urea nitrogen. This amazing task is handled in the mature, adult kidney by one million to a million and a half functioning nephrons each of which consists of a glomerulus, a proximal convoluted tubule, a loop of Henle, a distal convoluted tubule and collecting ducts. (Fig. 1). The filtration apparatus of the glomerulus is formed from an afferent arteriole which enters the glomerular space and divides into several major vascular channels, each of which then branches into capillaries that join again to form the efferent arteriole. The glomerular space has an endothelial lining and the basement membranes of the capillaries represent extensions of the basement membrane of the arteriole. Recent electron microscopy studies indicate that the basement membranes of the glomerular capillaries consist of a middle layer of dense, fairly homogenous material that is covered on both sides with cement layers. The relative discontinuity of the endothelial

lining is unique in that the numerous endothelial pores expose 30 per cent of the basement membrane of the glomerular capillaries directly to blood passing through the glomerulus; the basement membrane then is the only barrier between the circulating plasma and the glomerular filtrate.

The plasma to be filtered at the glomerulus contains proteins, which are not appreciably filtered, nitrogenous products of metabolism (urea, uric acid, creatinine), the acid load of metabolism (sulfates, phosphates, carbonates, acetates, chlorides and miscellaneous organic acids), water, food products (glucose, amino-acids, vitamins) and bases or cations (sodium, potassium, magnesium, calcium). One hundred and eighty liters per 24 hours of the above protein-free filtrate pass through the glomerular lining and present at the proximal tubule as a fluid with a specific gravity of 1.010, (300 miliosmoles/liter) pH 7.4 and at the rate of 130 ml. per minute. At the proximal tubule this tremendous volume of isotonic plasma filtrate is iso-osmotically reduced in volume by 85 per cent via re-absorption through the proximal tubule back into the circulation. This absorption includes 85 per cent of the water, 85 per cent of the salt, 85 per cent of the potassium, chloride, magnesium and calcium, 100 per cent of the glucose, 90 per cent of the uric acid and 57 per cent of the urea. It is thought that this general proximal tubular function is under the control of the adrenal cortex. (It is at this point that diuresis is produced by the use of mercurial and thiazide diuretics.)

There is no essential change in the composition of the filtrate at this time and the 15 per cent of the volume remaining (25 liters) of isotonic filtrate descends down the loop of Henle, and as it approaches the hypertonic medulla, sodium diffuses into this filtrate from the medulla until it becomes hypertonic in the medullary portion of the loop; as the filtrate ascends the loop, sodium is pumped out so that it again becomes hypotonic on arrival at the distal tubule. The energy derived from this system of "sodium pump" and "counter-current multiplier system" of the loop of Henle probably supplies energy for function of the nephron. At any rate, the relatively hypotonic glomerular filtrate of approximately 25 liters arrives at the distal tubule where changes in composition will now be made in order to excrete the waste products and at the same time conserve water, sodium and potassium; the latter have been "obligated" to the acid radicals being excreted in order to maintain electrical neutrality. (Fig. 1).

It is in the distal tubule that the stronger inorganic acids, which must have "base" for excretion as salts, are handled in such a manner that sodium and potassium are replaced while the weak organic acids are excreted as acids. Several basic mechanisms, which operate in the distal tubular cells, are responsible for the base conservation process; these result in the acidification of the urine. The pH of the glomerular filtrate as it reaches the distal tubule is still 7.4 but by the time the filtrate is voided as urine the pH has dropped to six or below. The processes necessary for acidification and base conservation are as follows:

Process ♯ 1 Ammonia (NH_3) formed from glutamine.

Process ♯ 2 the formation of hydrogen $(H)^+$ and bicarbonate ions $(HCO_3)^-$ from carbonic acid (water and CO_2) through the carbonic anhydrase enzyme system; this reaction supplies hydrogen ions for combination with the ammonia to form ammonium ions which in turn combine with acid radicals. The hydrogen ions also exchange directly with potassium replacing and conserving potassium, and are excreted with acid radicals. Hydrogen ions may replace half of the sodium ions in sodium phosphate or sulfate, i.e., sodium hydrogen phosphate or sodium hydrogen sulfate. The result of all of the above is that sodium and potassium are reabsorbed into the blood stream while the acids are excreted in the urine as ammonium or mixed salts or as weak acids. Excess bicarbonate is converted to carbonic acid by hydrogen and is excreted through the lungs

as CO_2. Depending on the body needs for acid and base these processes will adjust the amount of sodium and potassium to be excreted or conserved and the pH of the plasma will remain at 7.4. All of this exquisitely fine adjustment is probably under control of aldosterone.

After leaving the distal tubule, the glomerular filtrate has the solute composition that will appear in the urine but still is too large in volume. Twenty-four of the 25 liters must be re-absorbed in the passage through the collecting ducts whose permeability to water is controlled by vasopressin, the secretion of the posterior pituitary (antidiuretic hormone). The final result is a urine of approximately one to one and a half liters as contrasted to a glomerular filtrate of 180 liters, a urinary specific gravity of 1.025 or above (miliosmoles 850 to 1200) as contrasted to a glomerular filtrate specific gravity of 1.010, (m.o.s. 300), a urinary pH> 6 as contrasted to a glomerular filtrate of 7.4 and the absence of protein, sugar or microscopic elements in the urine.

E. Discussion of Renal Function Tests

1. *Urinalysis*

a. *Specific Gravity*—The specific gravity of a concentrated urine specimen should be above 1.025 indicating good concentrating ability of the distal convoluted tubules and collecting ducts and adequate posterior pituitary stimulation. Under maximal antidiuretic stimulation the normal kidney is capable of concentrating the urine to approximately four times that of plasma, i.e., 1200 miliosmoles vs. 300 miliosmoles. Corrections must be made for faulty urinometers, temperatures—(where wide fluctuations exist), presence of more than 2+ protein or any amount of sugar. A morning urine specimen obtained following a "dry" supper and before eating, will usually be adequate; for maximum stimulation pitressin must be given. Inability to concentrate urine may be due to:

(1) absence of antidiuretic hormone as in diabetes insipidus,

(2) failure of otherwise normal nephrons to respond to antidiuretic hormone as in nephrogenic diabetes insipidus,

(3) increased load of solute excretion producing osmotic diuresis or use of diuretic,

(4) alteration in nephron (distal tubular function) caused by acute or chronic renal disease. The latter may occur early in disease affecting the distal tubule (interstitium) such as early chronic pyelonephritis. Abnormality in ability to dilute the urine occurs relatively late in acquired renal disease and is not a good test. Failure to concentrate may also occur in Addison's Disease, malabsorption states, and inappropriate antidiuretic hormone secretion.

b. *pH*—A fresh, 24 hour urine specimen is always *slightly acid* because the end products of metabolism are acid. Over a 24 hour period, however, the variations of urinary pH may be marked. Ninety per cent of random, fresh, urine specimens in normal subjects will have a pH of below 6.6 and only 1 per cent exceed 7.1 (average 5.85). The exceptions are:

(1) the usual alkaline tide following meals,

(2) a strict vegetarian may have an alkaline urine at all times,

(3) an "old" urine in which ammonium splitting organisms have propagated at room temperature,

(4) infection of the GU tract with ammonia producers,

(5) conditions of renal potassium loss as in primary aldosteronism (should be considered in all hyper-

tensive patients with persistent elevation of the urinary pH),

(6) renal tubular acidosis—although a rare disease it results in alkaline urine because the distal tubules have lost considerable ability to excrete acid. (This is a congenital disease, however, acquired diseases may occasionally develop the same defect, i.e., chronic pyelonephritis.)

c. *Chemical tests*—The presence of urinary protein or glucose may indicate renal or metabolic disease, however, there are situations as orthostatic proteinuria and low-threshold glycosuria which may not indicate disease. As more renal biopsies are being reported, we find that many of the cases of "essential proteinuria" may actually be latent nephritis, nephrosis or pyelonephritis. Fever, emotional tension, vigorous exercise, heart failure, hypertension, may also produce proteinuria.

d. *Microscopic examination*—a clean, freshly voided specimen after proper local preparation (male or female) can often be treated like a catheterized specimen. Rare white or red cells may not be significant but clumps of white cells indicate urinary tract infection. White or red cell casts and granular or broad casts indicate upper urinary tract lesions. Bacteria noted on a gram stain smear of the fresh sediment, indicate a concentration of bacteria of at least 100,000 per milliliter and point towards infection rather than contamination. Existence of infection can be further substantiated by colony counts and cultures. Cultures, however, may be plated from the same, freshly voided specimen and the predominant organism compared to that noted on the gram stained smear. It thus is rarely necessary to catheterize. It must be remembered that formed elements may be passed in the urine intermittently hence the necessity of repeated analyses where suspicion exists.

2. *Glomerular filtration rate*—tests the glomerulo-proximal tubule function. The blood constituent employed to measure G. F. R. should be a substance that has a fairly constant rate of production, is completely filterable and is not altered in any way during passage down the tubule. Urea nitrogen and serum creatinine are two blood constituents that are commonly used to measure glomerular filtration. Urea is not ideal for the following reasons:

(1) It is the primary nitrogenous end product of protein metabolism—produced in the liver and is therefore affected by liver disease,

(2) approximately 60 per cent of the urea is reabsorbed in the proximal tubule while 40 per cent is excreted. It also varies with dietary nitrogen intake, endogenous protein catabolism, rate of urea synthesis in the liver and the rate of urine flow,

(3) the serum level of urea nitrogen may rise with perfectly normal renal function in situations of high protein intake and dehydration and also with internal bleeding (pre-renal azotemia). On the other hand, it may not rise at all until functioning renal mass has been reduced approximately 60 per cent. (The BUN test is therefore chiefly useful to follow the progress of uremia but is not useful as a glomerular function test.) Urea may be used in a clearance test but the clearance is normally only 60 to 65 per cent of glomerular filtration rate (loss in the proximal tubule) and therefore is not as useful as creatinine.

Creatinine is a much more ideal blood constituent for G. F. R. measurement. It is also an important protein end product, however, it is primarily derived from the muscle creatine and not from the diet. Even extensive changes in dietary protein will not affect the creatinine produced. The excretion is constant and is directly

proportional to the muscle mass of the individual. Only in situations of severe muscle wasting is there any change in serum creatinine. The normal serum creatinine is fairly fixed at 1± 0.2 gms. per cent. It is completely filtered, highly soluble, and not altered in the body. It is therefore analogous to inulin used in clearance measurement. Since it is completely filtered and excreted without change or loss, its clearance will be a good indicator of glomerular filtrate rate.

The clearance of a substance from the blood follows the formula: $CL = \frac{UV}{P.}$ "U" is the urine concentration, "V" the urine volume and "P" the plasma concentration of the substance. Since approximately 1 gm. of creatinine is constantly excreted per 24 hours the numerator "UV" will be constant or equal to 1 therefore $CL = \frac{1}{P}$. Therefore the clearance of creatinine is inversely proportional to its serum level; one can say qualitatively that if the serum creatinine level is doubled the glomerular filtration rate has been reduced to one-half of the normal, if the serum creatinine is tripled, the G. F. R. is one-third, etc. To obtain a quantitative clearance rate, however, the creatinine clearance test as performed in the office or in the hospital is excellent. It is the most practical way to measure glomerular filtration. The results obtained are approximately the same as with inulin clearance; the normal value of G. F. R. (creatinine) is approximately 140 ± 27 ml. per minute. The test may be determined for short periods (2 to 4 hours) if the patient does not have difficulty voiding completely; a 24 hour period of collection would be slightly more accurate. The test is performed by having all of the urine that the patient voids over the determined period of time collected while the patient is encouraged to drink a great deal of water. The serum creatinine determination is performed at approximately the mid-portion of this period. The formula $C = \frac{UV}{P}$ is then applicable.

3. *Distal tubular function*—involves the operation of the bicarbonate "factory" or acid-base balance, conservation of sodium and potassium and the concentration of the urine. Measurement of the 24 hour urine volume, specific gravity (or osmolarity) and maximum concentrating ability, either through Fishberg test or pitressin stimulation, will measure concentrating ability. Measurement of the 24 hour excretion of sodium and potassium in conjunction with serum levels will indicate excessive loss of either substance and will indicate how well the distal tubule is conserving these critical elements. Serum pH determination will indicate acidosis or alkalosis and hence acid-base balance.

(a) Renal sodium wasting may occur in:

1. acquired kidney disease with renal insufficiency due to the osmotic diuretic effect of large solute loads carried by a reduced number of nephrons or,

2. a specific renal tubular defect in the distal tubule (tubular acidosis and chronic pyelonephritis). A salt restriction test would pick up these cases; in patients with chronic renal insufficiency rigid salt restriction results in a negative sodium balance, dehydration and super-imposed pre-renal azotemia, therefore, this test will also define the maximum degree of salt restriction permissible. In practice the patient may be placed on a 200 mg. sodium diet for three days and a 24 hour urine specimen collected. The patient is weighed, the hematocrit, serum sodium and creatinine are determined before and after the test. (Patient should not have been edematous or dehydrated. If there is any question

of dehydration the patient should be salt-loaded with 100 to 150 mEq. of sodium for three to five days before the test.) In a normal person the 24 hour urinary sodium is reduced to 10 mEq. or less and there is no change in the hematocrit, serum sodium or creatinine. In salt wasting the urinary sodium is above 200 mEq. per day, weight loss is significant, the serum creatinine rises and serum sodium falls. (A simple qualitative urinary sodium can be determined by utilizing a nebulizer containing one cc of urine which is sprayed into a bunsen flame. A bright yellow color will indicate a loss of salt in excess of 10 mEq. per liter.)

(b) Polyuria—To test response to ADH —300 cc of 2½ per cent saline is given intravenously over a 45 minute period. In the normal individual this would provoke a distinct antidiuresis; in compulsive water drinkers, where there is usually an inadequate response to pitressin, it would also produce a modest antidiuresis. Absence of response would indicate diabetes insipidus of either pituitary or renal origin.

Another test would be injection of aqueous vasopressin (pitressin) intravenously or intramuscularly after ten hours of fluid and water deprivation. The specific gravity should increase above 1.022 (indicates the response of the distal tubule to ADH).

(c) Alkaline Urine—If the urine is persistently alkaline without evidence of infection, it would suggest a defect in acid secretion. This can be tested by giving ammonium chloride four to eight gms. daily for four days. Check urine pH and tritratable acidity. In the normal it should drop below pH of 5.5. Failure to drop would indicate renal tubular acidosis. Further proof is an increase in urinary sodium and chloride excretion indicating the characteristic defect in hydrogen ion exchange.

A 24-hour ammonium excretion would determine whether the kidneys are able to form ammonia. This should rise under ammonium chloride loading.

(d) Other tests—to differentiate between diffuse renal disease or discrete function defect—measure glomerular filtration rate by creatinine clearance—should be normal in the latter. Specific defects—check for hypokalemia and hypercalcemia by serum tests. Rule out obstructive GU disease.

Amino-aciduria can be checked. Amino-acid nitrogen excretion normal is 50 to 150 mgs./24 hour. The organic aciduria can also be checked and the normal is usually approximately 60 mEq. per day.

4. *Phenosulfonphthalein test* (PSP):—This is not a good test for renal function since 90 per cent of the injected dye is bound to albumin and therefore is not filtered at the glomerulus. Excretion by the tubule depends chiefly on renal plasma flow which recirculates the dye. As the albumin-PSP complex recirculates through the kidney more and more of it is excreted until finally about 90 per cent of it is excreted in two hours. The significant period, however, would be the first 15 minutes when at least 30 or 35 per cent should be excreted. The adequacy of bladder emptying is important in this test. Other chromagens in the urine may interfere. The test really does not indicate any particular type of renal impairment and is therefore not a very useful test. Its greatest usefulness would be as a screening test.

5. *Acid loading test* (ammonium chloride test of Wrong and Davies)—determines quantity of hydrogen ions excreted in urine in a certain period of time. Patients with renal tubular acidosis have diminished ability to excrete hydrogen ions. Patients with acquired renal disease have a normal fall in urine pH.

F. Anatomical Studies:

1. Intravenous pyelogram—requires fairly good concentrating ability of the kidneys for test. Cannot be done in azotemic patients for this reason. The speed of appearance of dye in each kidney indicates over-all function of the kidney (should appear within three minutes). Slow appearance in one kidney where there is suspicion of renal vascular disease may implicate that kidney. The main purpose of the pyelogram is to rule out obstruction, etc. Should be performed fairly routinely.

2. Retrograde pyelogram—performed when intravenous pyelogram is not satisfactory.

3. Aortogram—very useful to outline renal arteries and aorta in suspected renal vascular disease. Certainly not a routine test.

4. Renal biopsy—will reveal etiology of the asymptomatic proteinurias and other obscure renal lesions.

5. Radio-hippuran test—still not standardized too well but may be useful in future to measure renal blood flow and function.

CLINICAL SYNDROMES

Utilizing the history, physical examination, a careful urinalysis and the proper renal function test, one can usually separate chronic renal disease into two basic groups, i.e., glomerular or tubular. The glomerulus and proximal tubule can be considered as one functioning unit (glomerular) while the distal tubule—collecting duct system (tubular) is another. Examples of tubular disease are chronic pyelonephritis (before the stage of contracted kidneys with hypertension), tubular acidosis, hypokalemic nephropathy, etc. The former (glomerular) syndrome would be characterized by early hypertension, azotemia, edema, vascular changes in the fundi, proteinuria and microscopic bodies in the urine—(RBC, casts). The primary defect here is that of retention of the end products of metabolism due to lack of filtration while involvement of the afferent arteriole (juxta-glomerular apparatus) results in hypertension. The distal tubular disease, on the other hand, would be characterized by problems in acid-base balance, electrolyte depletion, dehydration; there would be poor concentration of urine early and, only in the late stage, changes in blood pressure and azotemia. The individual with glomerular disease would follow the pattern of acute nephritis and might exhibit a high specific gravity, azotemia, hypertension and edema early. Death would result because of uremia and its complications. The "tubular type" of patient would be in danger because of excessive loss of water and electrolytes and the acid-base abnormalities. The former must be treated by reducing metabolism and by artificial removal of the nitrogenous waste; the latter could be easily managed by continuous replacement of the water and electrolyte losses and re-establishment of acid-base balance. The prognosis would be much better in the "tubular type" of disease. It thus is essential to identify the basic defect in each case of chronic renal disease since the therapy and prognosis is so vastly different. This can usually be accomplished by utilizing the above physiological approach.

TREATMENT

1. *Chronic renal disease with azotemia*—(glomerular usually)—The best clinical example of this situation is the patient with chronic glomerulonephritis who is azotemic, hypertensive and relatively young (20-40). Most of the nephrons have been destroyed (especially the glomeruli); the tremendous

amount of plasma filtrate and solute load must be handled by a very few nephrons. This results in a high volume of urine but poor removal of nitrogenous and acid wastes plus considerable loss of electrolytes. Anemia results because of hemolysis and bone marrow depression; hypertension results because of vascular involvement and the patient is edematous chiefly because of excessive loss of protein. He may be losing or retaining excessive amounts of salt and water—usually the latter. These individuals die from the complications of uremia (chiefly hemorrhages), super-imposed infections or overwhelming crises which destroy the precarious renal balance. Death can also occur prematurely because of iatrogenic rigid salt restriction, dehydration or use of potent hypotensive drugs. Surgery is extremely harmful. Yet, given good care, the individual in this situation can live for a long time in spite of a BUN of 100 or more and a glomerular filtration rate reduced to 10-20 milliliters per minute. Survival would require shielding patient from all possible stress. The following course of treatment would be beneficial:

a. Hypertension—If indicated, the hypertension can be reduced gently by mild salt restriction, sedation, reserpine; a severe drop may further embarrass renal blood flow.

b. Anemia—The anemia need not be corrected since a hemoglobin of 8-9 gms. per cent is perfectly compatible with the sedentary type of life of a chronic nephritic. If correction is attempted, washed red cells should be used. (There is no response to hematinics, iron or B 12.)

c. Hyperkalemia—Chronic uremics as a rule do not have trouble with hyperkalemia unless acute renal failure supervenes. In fact, there may be potassium depletion due to tubular involvement. A 24 hour urine analysis for electrolyte losses will clarify.

d. The diet should be low in protein and high in carbohydrate and fat; this reduces the urea production tremendously (from 30 to 3 gms./day). Example: COH= 300 Gm, F= 100 Gm, P= 40 Gm.

e. Fluids—The patient's thirst will usually determine the amount of water needed but it should always be as great as the urine volume. Care must especially be taken during acute illnesses or surgery so that dehydration does not occur.

f. Sodium—The salt intake should not be set at an arbitrary figure even though patient is hypertensive or edematous. The actual urinary salt loss per 24 hours should be measured and the salt intake adjusted to that level. Where edema or hypertension exists, the salt intake can be reduced slightly below the loss thus aiding the loss of fluid.

g. The potassium in the diet can be normal unless there is excessive loss or retention; this can be determined by serum and urinary potassium determinations.

h. Exercise—Patient's activity should be curtailed within limits of fatigue and he should be watched carefully for possible urinary or any other type of infection.

i. Infections—Antibiotics that are not excreted by the kidneys (do not use streptomycin, kanmycin and use care with tetracycline) should be employed when needed.

With proper precautions these patients can live a long time and be made quite comfortable in spite of their limited reserve.

2. *Chronic distal tubular disease*—the most common variety in clinical practice is chronic pyelonephritis prior to onset of hypertension; this occurs in patients with history of frequent urinary infections frequently with renal stones who do not have hypertension and excrete a tremendous amount of urine containing a great quantity of salt and potassium. The situation can be recognized by the urinary and serum concentration of electrolytes. These patients easily become dehydrated and go into shock because of loss of extracellular volume; they behave very much like the individual who develops heat exhaus-

tion from sweating. When recognized and treated by replacement of the appropriate amount of salt, potassium and water plus vigorous treatment of infection, these patients will survive for many years. A similar but less frequent situation exists in congenital tubular acidosis where systemic acidosis occurs due to a tubular defect which prevents acidification of the urine. These patients become life-long problems and the proper correction of the acid balance, water, salt and other food stuff losses will be life-saving. The prognosis, in general, is better than that in the glomerular diseases.

3. *Acute renal failure*—this catastrophe results whenever there is a sudden, severe, curtailment of renal blood flow. It may occur in the perfectly normal individual following the "shock or crush syndrome" due to accident, severe loss of blood, severe illness with associated dehydration, post-surgery, transfusion reactions or any severe antigen-antibody reaction. The common denominator is acute deprivation of renal blood flow due to sudden overwhelming catastrophe. It frequently occurs in the individual with chronic renal disease who develops an infection or is exposed to surgery or accident; the already limited renal blood flow is sharply curtailed.

The warning heralding acute renal failure, in either case, is a decrease of urine volume to below 500 cc /24 hours; complete anuria results when the volume is below 100 cc per 24 hours. With this in mind, it is essential that all critically ill patients should have the urine output monitored carefully.

A urine volume below 100 cc/24 hours implies failure of excretion of the metabolic wastes; the stage is now set for the complications of acute anuria (uremia). Such a decrease in renal excretion will result in a slow rise in BUN which, however, will not be an important toxic factor for at least seven to ten days. The serum potassium, however, rises much faster and may increase at the rate of 0.5 mEq. per liter per day; at the concentration of 7 mEq./L it can be lethal because of cardio-toxic action. Therefore, within three or four days after onset of anuria, the individual is in mortal danger because of hyperkalemia. Water accumulation, on the other hand, will occur at a gradual rate and edema will not be a problem for some time. The prime objective of therapy then is to prevent the lethal hyperkalemia or infection, to minimize the uremia and not to supply more water than is necessary for metabolism while the basic precipitating factors are corrected. The following steps are designed to tide the individual over this critical period until the renal function resumes, as it usually will (five-seven days):

(1) Prevent water over-load—administer only 500 cc of water plus water lost by all routes, i.e., vomiting, diarrhea, sweating, etc. Indication of overload is gain or maintenance of weight; patient should lose one pound per day.

(2) Reduce the uremia by eliminating all proteins from the diet and supplying high carbohydrate and high fat diet, i.e., (200 to 300 grams carbohydrate—100 gm. fat). The urea production will decrease to 3 gms. per day. This can be achieved by giving hypertonic glucose intravenously or orally, by giving sugar and butterballs.

(3) Reduce potassium accumulation—

a. High carbohydrate plus insulin will drive the potassium in the serum into the cells.

b. Eliminating proteins reduces potassium intake. Fluids such as ginger ale, sweet tea, and root beer contain very little potassium and should be used.

c. Potassium-combining resins (Kayexalate or SKF resin)—orally 60 gms. per day or by retention enema in 20 per cent sorbital will produce a potassium losing diarrhea and also remove potassium from the serum. If this does not prevent hyperkalemia, then peritoneal dialysis or artificial kidney dialysis would be in order. Five, two-hour sessions of

peritoneal dialysis is equivalent to one, eight-hour session on the kidney.

d. Acidosis can be reduced by giving bicarbonate or lactate.

e. Infection, which can be lethal, is vigorously treated or prevented by antibiotics not excreted by the kidney.

f. Avoid all catabolic procedures which would increase the amount of urea and K^+ production—i.e., operations and blood transfusions. If transfusions are necessary, use fresh, washed, red cells.

g. Testosterone is a good anabolic agent and can be used to reduce catabolism. This can be given by injection at the rate of 100 mg. every other day for several days. Calcium gluconate must also be given to replace calcium loss in uremia.

h. Mannitol—25 per cent solution I.V., if given early may produce diuresis.

(4) Remove the factors responsible for the anuria.

The above conservative, expectant treatment of acute renal failure will enable the patient to survive until the factors that reduced the renal blood flow are corrected. The kidney will then begin to function, but because of distal tubular damage due to anoxia, may experience a profound diuresis with excessive loss of electrolytes and water. This must be anticipated and treated as needed. If treated judiciously, most of these patients will survive and will have return of adequate renal function.

SUMMARY

The management of chronic renal dysfunction is discussed in light of the involved anatomical segments and dynamic processes. The pertinent facts in the patient's history and the physical findings suggesting renal disease are discussed and the necessary laboratory tests required to pinpoint the abnormality and reveal the etiology are discussed. The pathophysiology of renal dysfunction is discussed in detail and renal dysfunction is divided into two major groups, i.e., the glomerular type of abnormality involving the glomerulus and proximal tubule and the tubular type of dysfunction which primarily involves the distal tubule and collecting ducts. It is pointed out that the prime function of the kidneys is that of excretion of the toxic acid products of metabolism without at the same time causing significant loss of water and base; this enables the body to maintain a normal extracellular fluid volume and remain in acid-base balance. This function is achieved by a kidney that can excrete a urine six times as dilute or four times as concentrated as the plasma in terms of its osmolarity.

The basic defects in the two major types of renal dysfunction are discussed and treatment indicated. The glomerular type of chronic renal dysfunction is chiefly seen in the nephritides while the tubular is commonly found in chronic pyelonephritis. Acute renal failure is discussed; early recognition and rational treatment is indicated.

It is pointed out that in spite of far-advanced renal dysfunction with azotemia and a glomerular filtration rate reduced to 10 to 20 ml/min. long-range survival can be anticipated provided that proper, judicious, and cautious therapy is instituted.

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Topical Application of B Complex Aqueous Solutions For Treatment of Thrush Via Serendipity

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Summary:

Quite by accident, while feeding house plants, it was discovered that various aqueous solutions of B complex stunted the growth of the molds which were spreading on the containers and dirt near these plants. Various aqueous dilutions of B complex were applied *in vitro*, to Sabauraud slants and blood agar in Petri dishes, which were seeded with lush growths of the plant mold. All dilutions (serial) killed these growths. Nine children with thrush were treated with 50 per cent aqueous B complex solution topically, and their Monilia Albicans growths disappeared within 48 hours. An elderly female amputee with uncontrolled diabetes mellitus exhibited a fulminating thrush of her tongue. She was treated similarly with 50 per cent aqueous solution of B complex, and her thrush was eliminated within 72 hours. These ten patients received oral antibiotics (penicillin or tetracyclin) concomitantly, which did not appear to interfere with the elimination of thrush of the tongue and oral cavity in these ten patients.

One of us grows plants in his office. The dirt and sides of the plant containers began to show lush growths of a penicillin-like mold which interfered with the growth of these plants, especially when this mold surrounded the plant stems. To overcome this difficulty, several drops of liver extract (crude) solution with some drops of B complex solution were added to water. This solution was used to water the plants in an attempt to revitalize their growth. However, it was noted that the excessive mold growths became devitalized. Then, in order to determine whether the liver extract or the B complex was the cause for impeding the growth of the mold, each substance was applied to different areas of mold growth. It was discovered that the liver extract produced more mold growth, while the B complex destroyed the mold.

Since Penicillin Notatum is related closely biologically to Monilia Albicans, which causes the growth of thrush in humans, a 50 per cent aqueous solution of B complex was applied directly to the thrush growths in three

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separate colored and six white children (*in vivo*). These thrush deposits became eliminated within 48 hours. A 70 year old colored uncontrolled diabetic amputee (both legs) exhibited a thick yellowish deposit on her tongue and pharyngeal areas. She was treated similarly. Within 48 hours, the thrush became eliminated. She remarked that since this therapy was completed she could again enjoy eating, since she had been unable to taste her food adequately for some years.

Each of the ten above patients was given either penicillin or oxytetracyclin orally while they were being treated topically with the 50 per cent aqueous solution of B complex. The use of these antibiotics did not appear to increase the growth of monilia albicans while their oral cavities and tongues were painted with the aqueous B complex solution (50 per cent). Each patient's oral cavity was painted with this solution after each meal and at bedtime.

The *in vitro* studies were performed with Petri dishes which contained blood agar. These were seeded with swabbings of the plant mold from the office plants. These mold growths appeared to spread more quickly when these Petri dishes were kept at room temperature rather than in the incubator.

An agar plate of one week's growth of mold was used for testing the lytic power of serial dilutions of B complex in water. These dilutions were prepared from a stock vial of B complex solutions. These serial dilutions were:

Tube ≠1 1:5 dilution (0.25 c.c. in 1 c.c. H_2O)

Tube ≠2 1:5 dilution ≠1 (0.25 c.c. in 1 c.c. H_2O)

Tube ≠3 1:5 dilution ≠2 (0.25 c.c. in 1 c.c. H_2O)

Tube ≠4 1:5 dilution ≠3 (0.25 c.c. in 1 c.c. H_2O)

Tube ≠5 1:5 dilution tube ≠4 (0.25 c.c. in 1 c. c. H_2O)

In all cases the mold so treated showed complete lysis in the area treated. Each test was completed in eight hours.

The first *in vitro* studies at the office employed various B complex solutions which contained different preservatives, since it was thought that the presence of these particular preservatives might have been the cause for the death of the molds. However, this was not found to be true, since each B complex preparation produced identical results which resulted in the death of the mold areas which had been so treated.

Nelson[1] wrote that "at present there is no completely effective agent" for treating thrush (monilia albicans)." We have not been able to locate any reference where topical B complex solutions have been used to treat monilial infections of the oral cavity. However, Sutton[2] wrote that g e n e r o u s amounts of B complex (parenterally) should be employed in such cases. Vitamin A with local agents was used to clear such a case by Ephraim.[3] Gargles, the application of gentian violet and Amphotericin® and sodium propionate have been used with varying success in the treatment for thrush infections. Lately Mycostatin® (Squibb) has been used as has a 10 per cent solution of formalin.

However, the topical use of B complex aqueous solution (50 per cent) can be employed without danger even to infants who have thrush. If they happen to swallow some of this solution, no harm can ensue.

Whether or not the topical application of B complex aqueous solutions might prove efficacious for the treatment of gastric moniliasis or even vaginal candidiasis remains to be seen.

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PROSTATITIS

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This is an important topic for all of us and especially, for the general practitioner who sees many of these patients. Like the common cold, prostatitis is prevalent, not thoroughly understood, and often difficult to treat.

I will first dispose of acute prostatitis (or trigonitis) briefly, by saying that it is similar to acute inflammatory processes anywhere in the body, and is usually followed by the chronic phase, which we will discuss at greater length. The symptoms of acute prostatitis are often severe and accompanied by considerable morbidity, dysuria, hematuria, urgency, and sometimes acute retention.

Chronic prostatitis. For convenience, I would like to group these patients according to age. The first group would be those from approximately 9 to 12 or 13, and these constitute a group in which one rarely expects to find prostatitis. On the other hand, in enuretics, boys with hypospadias, or those having congenital bands, meatal stenosis, or any condition requiring catheterization or instrumentation, there is the possibility of prostatitis developing. As little as one might suspect it, these children are greatly benefited by careful massage, and one should bear this in mind, especially in those I mentioned above who have had instrumentation.

The second group would be those in their late teens or early adult life, and these, of course, contract prostatitis by absorption from areas outside the urinary tract, such as bad teeth, infected tonsils, upper respiratory infections, and etc. In addition, however, they frequently develop congestion and swelling from ungratified sex desires and emotion. This produces not only swelling in the prostate, but congestion in the ducts as well; and therefore, evacuation of the secretion is hindered. This blocking of the normal

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escape routes accentuates the retention of secretion, and merely aggravates the infection in the prostate. Some of these patients relieve themselves by masturbation, which, of itself, may lead to prostatitis if practiced in excess. Evacuation is necessary to secure improvement in these patients and, though massage is a poor substitute for sex, it is "the best we have." In addition to absorption from outside and from ungratified sexual desires, there are still those who acquire prostatitis from either venereal infection, trichomonad infection, or other non-specific bacteria by extension up the urethra. Since the advent of the Sulfas and Penicillin, gonorrhea has been a much less important factor in this type of prostatitis than formerly; but the non-gonorrheal urethritis that we now have is often more difficult to permanently and completely eradicate than gonorrhea.

The third group are those in later adult life—around 40 or 50—who can, of course, contract prostatitis from outside the urinary tract just as those in earlier life and can contract urethritis, either venereal on non-specific, just as those in early ages. It is in this age group, however, that ungratified sexual life takes a different turn. Their wives have often had a change of life and with it, a lessening in their interest in sexual activity; and in the male, the sex drive may have lessened, and he himself have less inclination for frequent and regular evacuations. This brings on the same congestion, the same swelling and obstruction to the escape ducts, and the same prostatitis, as in the younger men. It is further complicated by the beginning prostatism of late adult life. It is difficult then, at this stage, to accurately differentiate between the symptoms that are caused by a swollen, congested prostate, on the one hand, and those of prostatism that is beginning on the other hand.

Treatment

The treatment of acute prostatitis consists of rest in bed, plenty of fluids, antibiotics, and possibly, very gentle massages. In cases where straining and dysuria are severe or acute retention develops, one must use an indwelling catheter no matter how much the patient might object to it. If abscess develops, this often must be drained, though this condition rarely develops nowadays with quick recognition of the true situation and the active use of antibiotics and the other measures mentioned above.

In chronic prostatitis, there are those of us in Urology who massage and those who do not. I belong to the group who believe that, once prostatitis has developed and the ducts are partially obstructed, and especially when the patient's sex life is such that adequate and regular evacuations are not adequate, regular massage therapy is by far the best way of handling these patients. I do not wish to over-emphasize the sexual aspect of my subject, but it is so important that a frank discussion of it is best between the physician and the patient. It should be pointed out that reasonable and regular normal evacuation is about the best therapy that we have, and that our massages are to be counted on as supplementary therapy. One would naturally search for outside foci in the teeth and tonsils and other areas and eliminate them when possible. I would like to digress a moment and point out that, for some reason not completely understood, most patients who have passed ureteral calculi either by themselves or by manipulation develop some prostatitis; and they should be followed after the passage of a stone with regular massages and check-ups for some months afterward.

Are antibiotics of any avail? Yes, they are, particularly in the acute conditions, and indeed, in some chronic conditions. However, since they must be carried through the blood stream and since the blood supply in the interstitial portions of the prostate gland is very meager, then only a very tiny percentage of the effective antibiotic elements ever reach the areas that need it most. For that reason, antibiotics have, as a rule, been of doubtful value in most cases of chronic prostatitis. Even when one secures improvement by this medication, the infection will return quickly as soon as it is discontinued, unless proper massages or other evacuation is practiced.

The use of sounds formerly was almost a prerequisite in the treatment of prostatitis and still is useful when stricture is present. In former times, when gonorrhea and the resultant strictures were prevalent, sounding probably was a most important part of the treatment; but this is seldom necessary now, and we rarely use it for routine purposes in the ordinary treatment of prostatitis without demonstrable stricture.

And now, a word about the frequency and duration of the treatment for prostatitis. So many patients ask the question, "When will I be well, and how long will this treatment take?" There is no ready answer to this question, and we can merely point out to them that, once the prostate is thoroughly inflamed and the ducts diseased and narrowed, then evacuation becomes incomplete, and the problem of prostatitis is then of long standing. The treatment, obviously, should not be given too frequently, maybe once a week or every two weeks at first, gradually lengthening the time between massages, as symptoms indicate. Once we reach the place where every three months or so is adequate, then the patient can be considered in satisfactory condition, but should continue to be treated three or four times a year, almost indefinitely. Indeed, I advise most of my patients and friends over forty to come in for fairly regular massages anyway, and there have been many occasions when this has proven a very fortunate practice. Not only is the prostatitis kept under better control and better observation, but early carcinomas and other changes are much more readily recognized and treated.

A few suggestions about the technique of massage would seem proper at this time. No one can tell you just how hard to press upon the gland when you are massaging it, and this pressure must obviously vary according to the individual and the degree and acuteness of the swelling of the gland. It is usually best to massage gently the first time or two until you have ascertained the true situation, and then you may gradually increase the pressure to tolerance with an eye toward any reactions that might have resulted from previous massages. In stroking the prostate, one would ordinarily stroke from above downward and from without inward, avoiding intense pressure on the urethra in the mid line. It is often wise to watch the secretion drip from the meatus in order to determine which portion of the gland yields the greatest amount of secretion. If there is one area larger than the other or firmer or more tender than elsewhere, it is often best to concentrate on that one specific area, for a few times, and not give the entire gland a thorough pressure for evacuation. Any nodules, such as those just mentioned, must be carefully evaluated for possible early carcinoma or calculus formation.

I would finally suggest that "when in doubt, massage gently" is a good rule until you are sure more firm pressure can be tolerated. I might call attention to the fact that overly aggressive massage can lead to worsening of the condition, and sometimes, epididymitis and other complications.

What do you do with the secretion obtained? First of all, in spite of the amount of pus that is present, we have experienced little success in attempting to culture it and determine what bacteria are present or what sensitivities might be shown. This is surprising and not altogether understood, but cultures are usually of no avail. An examination of the fresh, wet specimen under the microscope, immediately after massage, gives us the most information as to the amount of pus cells, the number of clumps present, the number of red cells present, the amount of debris, crystals, and so on. As the number of pus cells and clumps diminish, one can assume that the condition is improving; but the actual numerical count must not be taken too literally, as a definite indication of this improvement. One may massage a different area or exert different pressures or a patient may have evacuated himself, prior to coming to the office. Therefore, while a steady downtrend in the numerical count of pus cells in the secretion is imortant, one must not rely upon that too completely.

Most cases of prostatitis will improve with regular intercourse, massage, or general therapy as outlined above. Some, however, will prove resistant, and as time goes on, if they continually resist all conservative therapy then one must consider other measures which might be tried. A panendoscopic examination of the posterior urethra, bladder neck, and trigon might yield information that would be helpful. One would certainly calibrate the urethra with a sound to ascertain there is an adequate channel. Vasotomy, with irrigation of the ducts, has proven beneficial in some of our obstinate cases, and this need not render the patient sterile by any means. Some men advocate prostatectomy, and even suggest radical prostatectomy with removal of the seminal vesicles especially when iritis, arthritis or other conditions are present and a focus of infection seems to persist in the prostate and vesicles. This is pretty radical treatment and yet, a really obstinate case of prostatitis can be a serious thing if it is adversely affecting the body economy.

It seems proper at this point to warn against the assumption that a transurethral resection is indicated to remove the infected prostate and what little obstruction might be caused by the inflamed gland. One is tempted to do a transurethral resection since an incision is avoided and the gland is usually not very large at this stage. Also the patient will accept it more readily than he will an open surgical procedure. On the other hand, our experience has been very unfavorable with resection in these glands, because of the morbidity, infection, bleeding, and general dissatisfaction resulting from the procedure. One inevitably leaves a little fringe of infected gland, there is sloughing and infection remaining in this area, and the scarring and frequency of urination are too prevalent to permit its use except in very isolated cases. I would strongly urge open surgery, rather than transurethral surgery in cases that have marked prostatitis and require surgical removal.

Calculi develop in the prostate gland, usually from preceding infection, and oftentimes, prevent the eradication of prostatitis and make their removal essential. This is one area in which transurethral resection might be utilized, because the prostatitis has subsided ordinarily and is merely being aggravated by the presence of these calculi; thus unroofing them and removing them would be beneficial no matter what the resulting morbidity. If the collections of calcium are large and wide-spread, however, even here open prostatectomy is often preferable to transurethral resection. The mere presence of calculi, unless they cause symptoms and marked concentration of pus in the secretion, may be ignored and allowed to remain.

Hemospermia is a condition which must be differentiated from prostatitis of sufficient degree to cause red cells in the secretion. The patient will usually inform you that there is blood in the ejaculate, and this condition is rarely acute. In the massage, one can frequently have a pretty good idea that the blood is coming from the seminal vesicles, rather than from the prostate. It results from infection in the seminal vesicle and will usually respond to adequate and patient therapy.

Granulomatous prostatitis, according to Richards and Rubin, is an uncommon lesion. It may be confined to the prostate or be part of a generalized allergic process. The symptoms are those of bladder neck obstruction and the gland is firm to hard and may be mistaken for carcinoma. Histologically the tissue is packed with leukocytes, mostly eosinophiles. I mention this condition because there is evidence that some few instances of prostatic enlargement due to allergy have been reported. The localized form is treated as simple prostatic hypertrophy; the generalized variety may be but part of a fatal disease.



Editorials

AMA-ERF

Through its generosity and sense of responsibility toward young aspiring physicians, the medical profession is compiling one of the brightest chapters in the history of the American Medical Association.

Since 1951, when the AMA established its Funds for Medical Schools, members of the profession have contributed through this channel an average of more than one million dollars a year. Four times this amount is contributed annually by physicians directly to the nation's medical schools.

Physicians contribute to medical schools through AMA's Education and Research Foundation in two ways. Some designate a specific school to receive their donations, others donate to medical education in general. In the latter case, funds are distributed equally among the country's AMA-approved medical schools. In both cases, use of the money is unrestricted. The schools can use it as they see fit.

More than half of the schools use AMA-ERF grants to hire more faculty, to broaden their curricula, to retain and attract the high quality teachers essential to medical education. In several instances, the purchase of needed equipment has been made possible only through these grants. Improving buildings and libraries, establishing contingency funds, meeting operating expenses—these are some of the other major uses which medical school deans make of AMA-ERF contributions.

In 1963 Alabama physicians gave $8,477 to medical schools through AMA-ERF.

Funds for Medical Schools is a project of the AMA-Education and Research Foundation, a non-profit organization. Contributions to the funds are tax deductible.

The principal aims of AMA-ERF are to promote better public health by supporting medical education and research, to stimulate a career interest in medicine among talented young people, and to help medical students pay their own way through their long and costly training period.

Because AMA underwrites the expenses of the Foundation, none of the money collected is used for administrative expenses. Every donated dollar goes to work for the purpose the donor designates. A contribution to AMA-ERF is one of the most effective investments that can be made in the future of American medicine.

Beware The Slumber Mongers

"While millions of Americans are tossing and turning in their beds, a growing legion of slumber mongers are making hay peddling pills, powders, drinks, and devices designed to wring cash from the sleepless," according to an article in the current (September) Today's Health magazine, published by the American Medical Association.

The problem of sleeplessness is genuine and serious with even the best adjusted person occasionally having difficulty falling asleep, the article points out.

"Unfortunately, many of those on the rack of insomnia clutch frantically for any promised relief," the article said. "This is especially true of the majority of those suffering from chronic insomnia where the sleeplessness is due to causes that are described as 'neurotic.'"

Not all sleep aids are utterly valueless, the article continued. A few may actually be helpful where the insomnia is not too severe.

"But most of them are of little, if any, value in severe chronic conditions; some of the non-prescription medications may be dangerous because of a human tendency to believe that a bigger dose might improve the result; and practically all but the home remedies cost far too much for the purpose."

The chronic insomniac ultimately will turn to drugs since he will probably find no sustained relief from homemade remedies such as reading a dull book or counting sheep, or from gadgets which range from ear plugs to stuffed chairs advertised as being able to massage the occupant into a state of relaxation.

"In this area, that of the over-the-counter sleep preparations, the panacea peddlers find their Eldorado," according to the article.

Such products that may sell at a relatively low price when marketed for one purpose seem to leap in cost when packaged as a sleep promoter. For example, 30 pills containing mostly aspirin, some antihistamine and minute amounts of other sedatives cost $2. when sold as a sedative for sleeplessness while another antihistamine-aspirin preparation offered for relief of hay fever costs only about half as much.

A vastly more effective sedative, a prescription drug, can be had for about $1. for 30 tablets, the article pointed out.

Prescribed by a physician, barbiturates are usually effective in most sleeplessness and can be used for prolonged periods without ill effects unless the patient suffers from a severe personality disturbance, it said.

Over-the-counter preparations sold for sedation and relaxation, to ease tensions, or overcome insomnia generally contain one or more of three groups of drugs—antihistamines, hypnotics such as scopolamine, and sedatives of the bromide group, it was explained. Many also contain aspirin, vitamins and other substances not necessarily related to sleep.

With regard to the antihistamines, drowsiness is only a side effect produced by these drugs and does not always occur. In addition, the more effective antihistamines may not be sold without a prescription. Those that are sold without a prescription may be variable in effect.

The AMA Council on Drugs has said: "It is our opinion that it would not be a reliable remedy for a person suffering from insomnia. While certain persons do become drowsy when taking antihistamine preparations, such effect is not uniform and most persons will build up a tolerance for the drug."

Scopolamine is a toxic substance and can be included in non-prescription preparations only if the amount is so small as to be virtually inactive. Sedatives of the bromide group are generally sold over the counter in doses small enough to be harmless. However, there have been reports of serious symptoms resulting from overdoses of bromides and scopolamine sold in nonprescription products.

Author of the article is Bernard Seeman.

Auto Official Calls For Approval Of New Highway Program By 1968

Traffic congestion and accident rates will reach "intolerable levels" unless the interstate highway system is completed on time and Congress approves a new federal road-building program by 1968, an automotive executive said.

Byron J. Nichols, general manager of Chrysler Corporation's Dodge Division, urged immediate planning for a second major federal highway project. He said the program will be urgently needed when the 41,000-mile interstate network now being built is completed by 1972.

Addressing the Commanders Luncheon at the national AMVETS convention in Philadelphia. Nichols said the interstate system, and especially its urban freeway links, must be finished on time "so we can get on with the job of meeting still greater, future highway needs."

He declared:

"The interstate system is not an accomplishment we will be able to rest on for years. It is only a catch-up program. It is only a program to meet needs that had gone ignored from 1930 to 1956."

Nichols pointed out that the U. S. will have an estimated population of 250 million and about 120 million cars and trucks by 1980. He said motor vehicle mileage by 1980 will be about 85 per cent greater than it is today.

Most of the increases in population and vehicle travel will be in metropolitan areas, he added.

"With this much growth in population and motor vehicle travel ahead of us in the next 15 years," he declared, "traffic congestion and accident rates in American cities will reach intolerable levels unless the urban freeway links in the interstate system are completed and a new federal-aid highway-building program is ready to take up where the present program ends in 1972."

The auto executive told the veterans group that the modern divided highway "represents one of the greatest contributions ever made to automotive safety."

The interstate system, he said, "has been the key factor in holding the nation's highway fatality rate at a fairly constant level while miles driven have increased year after year."

"There is no doubt whatsoever that without this system, the deaths on our highways over the past several years would have been substantially higher."

He said the new highways are already saving an estimated 3,000 lives a year and will save about 8,000 a year when the system is completed.

"In the saving of human life, the development of these modern highways is second only to some of the greatest discoveries of medical science," he asserted.

He said the interstate system is "the biggest public works program ever undertaken in the entire history of man.

"And it is a remarkable example of constructive partnership between the federal government, the states, and private industry in meeting a critical national need."

Nichols said the freeways in the system have helped restore the central cities of large metropolitan areas. They have helped "reverse the trend of a few years ago, when spreading decay in older downtown areas was threatening the well-being of cities across the nation," he said.

He challenged the AMVETS to "make themselves heard" in their own communities in support of completing the present highway projects to begin in 1972.

"A great opportunity lies directly ahead of us in the development of better, more efficient urban transportation," he said. "And what we make of that opportunity will affect the lives of the overwhelming majority of the American people for generations to come.

Guest Editorial....

AUXILIARY-PARTNERS IN AMA-ERF

Medical Auxiliary members are busy these days making plans for AMA-ERF fund raising projects. They have many good ideas and want the help of you doctors in carrying them out.

First, I must mention that our drive for funds last year was most successful—far exceeding the amount raised the year before. Under the inspired and imaginative leadership of Mrs. Curtis Smith of Mobile, the Auxiliary members in Alabama raised $9,285.58. That is a tidy sum. We promise to top that this coming year with your help. I must prove that I, too, am a good storekeeper—and one with zest and imagination.

Seriously, all good Auxiliary members are interested in what you are interested in. GOOD medical schools help make GOOD doctors. Many of our young people, our own sons and daughters, will enter the field of medicine. We want to do our part to raise funds for better medical education and research. We are willing to work to keep medical schools as free as possible from government intervention and control. We want to help with the Loan Guarantee Fund for medical students who need a boost. We are proud to be partners with you in supporting AMA-ERF.

One great satisfaction in AMA-ERF is in being able to designate your contribution to the medical school of your choice. In a recent letter to me Dr. S. Richardson Hill, Dean of the Medical College of Alabama, expressed appreciation for the administration and staff for our work in AMA-ERF. He stated that they are especially grateful for all the AMA-ERF funds designated to come to the Medical College of Alabama.

When your Auxiliary wife begins to talk about our several plans do lend an ear. It may help you with your Christmas giving. Our plans include donations, of course, gratefully received. We have charms in gold and silver in the shape of the State of Alabama, compacts and lighters with a handsome emblem on them, AMA-ERF playing cards, stationery, sympathy and appreciation cards, and most helpful Christmas card plans. All of these are available on order. Your County Auxiliary AMA-ERF chairman will help you —or please communicate with

Mrs. W. D. Anderson
AMA-ERF Chairman, Alabama
30 Guilds Woods
Tuscaloosa, Alabama 35401

ANNOUNCING . . . .

The availability of the sixth and seventh guides in the series of "Guides to the Evaluation of Permanent Impairment" developed by the Committee on Rating of Mental and Physical Impairment. They are entitled:

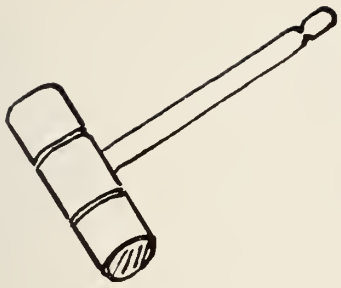
"Guides to the Evaluation of Permanent Impairment—The Digestive System" and "Guides to the Evaluation of Permanent Impairment—The Peripheral Spinal Nerves."

These guides, like all the others in the series, have been designed primarily for use by physicians. The guides are, however, of interest and use to all concerned with the medical, administrative, or judicial aspects of programs for the disabled. The previously published guides in the series deal with the extremities and back; the visual system; the cardiovascular system; ear, nose, throat, and related structures; and the central nervous system.

A limited number of copies of these guides may be obtained, without charge, upon written request to the Committee on Rating of Mental and Physical Impairment, 535 North Dearborn Street, Chicago, Illinois 60610.

Raymond M. McKeown, M. D.
Chairman

Committee on Rating of Mental and Physical Impairment



President's Page



In writing this column hardly a moment has passed since the previous one was written in which stirring events have not occurred regarding the course of HR 11865 through the Congress. The Democratic Convention in which the Alabama and Mississippi delegations were "deleted" passed into history. On August 31 the Social Security Amendments of 1964 (HR 11865) came to the floor of the Senate. Senator Albert Gore, of Tennessee, had expected to add his amendment to the bill as soon as it was presented. Instead, Senator Russell B. Long, of Louisiana, with only a handful of Senators present, offered an amendment to the Mills bill which had been approved by the Senate Finance Committee. The Long Amendment was to increase cash benefits and allowable earnings for present beneficiaries of Social Security. This would have used up available Social Security taxes and would have prevented any possibility of adding health insurance benefits in the foreseeable future.

Senator Gore was upset. With Mike Mansfield, Hubert Humphrey, and Paul H. Douglas coaching him, Senator Gore tacked the King-Anderson-Ribicoff-Gore amendment to the Long amendment "instead of the Mills bill proper." This would give a $7 increase in cash (not a percentage); would raise the tax base to $5,600 and would reduce nursing home care from 180 to 60 days.

"Wednesday, September 2, 1964 should be remembered as a day of mourning by Ameri-

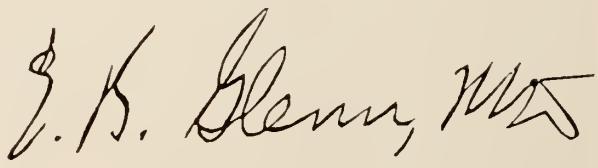
can Medicine" was stated on September 4 by Marjorie Shearon, Editor of "Challenge to Socialism." The vote favoring the Gore amendment was 49-44 as everyone knows. Unfortunately one of our Senators was hospitalized at University Hospital, Birmingham, the night before the voting, and, of course, was absent on the day the vote was taken. The Senator had received a telegram from the undersigned prior to his re-election in 1962 informing him of personal support of his candidacy. Other known sources of physician support indicated that he was well thought of by the medical profession, but he has frequently stated that "the doctors nearly beat me." The Senator's prestige in health legislation is unquestioned.

The final amendment passed 60-28. The tax base was raised to $5,600, the tax rate was raised to 10.4 per cent of taxable payrolls and a straight $7 a month increase in benefits was given to all beneficiaries.

A group of "friends of medicine" and several members of the Association met with a Washington representative of the AMA before the bill was brought up in the Senate. This meeting was held in Birmingham to review the voting possibilities of the Representatives from Alabama. Four of them were known to be opposed to the Senate-passed bill, but four were doubtful. The detailed alignment politically of each of these men was known to the AMA representative. This information was passed on to members of the Association who were in position to contact the Alabama Congressmen. Answers of all sorts were received from the doubtful ones. The most evident fact in reviewing these answers was that the Administration had intimidated these men with loss of appropriations or offered them positions in the Government to get their vote. The membership of the Association and friends such as the Alabama Trucking Association, the Farm Bureau, and the Alabama Chamber of Commerce, individuals in City and State government and others responded magnificently to the call for telegrams to the Representatives. Representative George Andrews' office informed some of our members that as of September 13 he had received 600 telegrams (the letter to the membership regarding the telegraphic campaign was mailed from the Central Office on September 4). Representative Andrews' office requested that no more telegrams be sent since he had 600 already and he indicated that he was opposed to this legislation.

On September 15 the bill was passed to the Senate-House Conference Committee. The administrative forces "Beat" a strategic retreat since they felt they did not have enough votes in the House to pass the Senate amendment. It was felt by the news commentators that this bill would probably not come up again this session.

What finally happens will be known before this column is printed. But we have learned that we must be organized down to the County Society level for national elections and that communications must be rapid and accurate. "Physicians, it would seem, are expendable" is a quote from the "Challenge to Socialism." The Doctors' Draft as far as the Military Establishment is concerned was the opening wedge. More specific, ways and means politically must be devised to help us to stand together against the onslaughts of socialization.



E. B. Glenn, M. D.



ASSOCIATION FORUM

Medicine and Religion

Arne E. Larson, Assistant Director

Department of Medicine—Religion, American Medical Association

Medical leaders have long recognized the fact that man cannot be separated into parts in the care and treatment of illness. Man, as a whole being, is affected by spiritual, mental, and psychological as well as physical factors.

The goal of all medicine is to obtain the best of health conditions for the human race. It is indeed good to have the best degree of rapport with the clergy so that the best care and treatment of the individual patient may go forward. This brings the highest possible degree of help and consideration for the needs of both the patient and his family.

One vital factor in the total health of a person is his faith. It is not a matter of whether we agree or disagree or accept his particular type or degree of faith. The patient has faith and we must deal with the patient within the realm of his faith.

Thus, religion—practical, working religion such as is needed in the care of the sick—is at once a source of help and comfort to both physician and patient.

For these reasons the Board of Trustees of the American Medical Association established a Committee on Medicine and Religion. Dr. Paul B. McCleave, an ordained clergyman, was invited by AMA to become director of the new Department of Medicine and Religion. The department began its task in September of 1961. Since that time a great deal of research has gone on in this field including consultation with heads of various faith groups and physicians. During the early months of the new program many pilot projects were carried on to determine the best way to proceed. Total scope of this effort was then defined in four major areas:

1. Physician-Clergy Relations in Total Patient Care
2. Hospital Chaplaincy and Clinical Pastoral Education
3. Medical School and Nursing School Education
4. Theological Education

Following the initial formation of the department, its goals and objectives, plans were made to encourage each state medical association to establish a committee for this work, or to assign the task to an existing committee. At this time forty-six states have accom-

plished this. Generally, the state group encourages and assists each county society to:

1. establish its own committee and introduce the subject to its members;
2. plan and carry on a continuing dialogue between clergy of all faiths and physicians;
3. make best use of all resource material available for programs.

In addition, state committees plan programs for annual meetings and provide training sessions for county chairmen.

Over 400 county societies have engaged in one or more programs involving the clergy and physicians. Topics for their discussions range from discussing problems related to hospital procedures and relationships, to the moral ethical responsibilities of both professions in organ transplants, use of the heart-lung machine and the kidney machines. Maintaining life through ordinary and extraordinary means is currently of great interest and importance.

For long a myth has been abroad that a conflict exists between religion and science and that men of science, including physicians, take a dim view of religion in general, practice it with indifference and often deny its reality. On the contrary, the physicians with whom we come in daily contact are, in the majority of instances, active members of some church; they are positive in their religious belief; they practice their faith in their profession daily; they contribute substantially of their time and money to support of the church and its activity. Comparing a given number of physicians with equal numbers of persons from other fields, their interest and active participation in church and civic affairs will match favorably anywhere.

Differences do exist between the clergy and the physicians that sometimes stand in the way of the best possible care of patients. However, the limited experience of many groups, currently in communication, proves these can be resolved to the satisfaction of members in both professional groups. Involvement in this program by county medical societies can and will lead to improvement of relationships and general patient care.

It is then appropriate that these two professions come to a closer understanding and draw upon the resources of each other in their daily activities in the service of God's creation—mankind.

NURSING NEWSLETTER

THE NEW DIPLOMA SCHOOLS

Diploma schools of nursing today prepare approximately 80 per cent of the students graduated each year from basic nursing programs. These hospital schools have undergone great changes since the first one was organized in this country 90 years ago. In the early years the changes came in the care of patients and in the housekeeping of hospitals; today, the changes are in the nature of the schools themselves. Some of these recent changes, particularly in teaching and learning, are described in this article.

(Frances K. Peterson, "Education for Nursing Practice—The New Diploma Schools," American Journal of Nursing, 64: 68, May, 1964)

ASSOCIATE DEGREE EDUCATION

Begun as an experiment 12 years ago, associate degree programs in nursing today prepare about five per cent of the students graduated each year from basic nursing programs. The question most frequently raised about associate degree education in nursing probably is, how can a nurse learn everything she needs to know in only two years? In seeking an answer to this and other questions, the Journal's contributing editor talked to directors and faculty members in associate degree programs, nursing service directors who have observed the performance of graduates, and some graduates themselves.

(American Journal of Nursing, "Education for Nursing Practice—The Associate Degree Program," 64: 68, May, 1964)

BACCALAUREATE EDUCATION

Baccalaureate programs in nursing today prepare approximately 15 per cent of the students graduated each year from basic nursing programs. It is frequently stated that such enrollments should be increased since this is the best route to graduate preparation for teaching, supervision, and administration—the critical needs in nursing today. Baccalaureate programs for nurses have followed various patterns in past years. Not all of them have been sound, says this noted nursing educator. The author describes those patterns and discusses them in relation to the common characteristics found in all baccalaureate education.

(Mildred E. Newton, "Education for Nursing Practice—Nurses' Caps and Bachelors' Gowns," American Journal of Nursing, 64: 68, May, 1964)

ROLE OF ANA AND NLN IN STATE BOARD TEST POOL EXAMINATIONS

Questions concerning the roles of the American Nurses' Association and the National League for Nursing in relation to the State Board Test Pool Examination were apparently resolved at a meeting of the ANA Committee of State Boards of Nursing, June 9-10.

Earlier the ANA had taken issue with an NLN board authorization to create an NLN Advisory Committee of Boards of Nursing. This action taken in January, ANA believed, would endanger the system used today through which state boards of nursing cooperatively develop and use licensing examinations. It was stated that creation of an NLN committee would make it possible to bypass the ANA Committee of State Boards of Nursing and permit development of policies and procedures regarding licensing examinations by persons outside of nursing.

NLN staff agreed that the ANA committee was the **policy-making group** for the State Board Test Pool Examinations, but expressed concern about not being more involved in discussions preceding the formulation of policy.

(American Journal of Nursing, "ANA, NLN Resolve Questions of State Board Relationships," 64: 28, July, 1964)

INTERACTION IN THE OPERATING ROOM

How does the operating room nurse assist in carrying out the health plan by providing special nursing care in a unique setting—one which can be called "bedside" in a real sense? How does the nurse actively participate in the care of any patient undergoing surgery? How do her relationships with other members of the health team promote a better understanding of the patient? What are some of the nursing activities in the operating room that would indicate collaboration? The objective of this article is to answer these and other questions set forth by the author.

(Sister Mary Virginia Clare, O. P., R. N., "Professional Collaboration in Operating Room Nursing," AORN Journal, March-April, 1964)

ANA CONVENTION—A SUMMARY

The theme of this year's convention was "The Knowledge Explosion—Its Impact on Nursing and Health Care." The summary of the convention includes results of the ANA elections, a report of the House of Delegates actions, and the various sections in the ANA organization. Also included is a review of the numerous clinical sessions and papers.

(American Journal of Nursing, "Nurses Convene," 64: 84, July, 1964)

NLN STATEMENT OF BELIEFS AND RECOMMENDATIONS REGARDING BACCALAUREATE EDUCATION

The original statement was developed by the enlarged Subcommittee on Undergrad-

uate Education and was submitted to and accepted by the NLN Steering Committee and Council of Member Agencies of the Department of Baccalaureate and Higher Degree Programs in the fall of 1963. The essence of this statement is unaltered. The statement includes the basic beliefs of the NLN, its recommendations concerning recruitment, advanced standing, application of criteria, and identification of programs.

(Nursing Outlook, "Statement of Beliefs and Recommendations Regarding Baccalaureate Nursing Programs Admitting Registered Nurse Students," 12: 57, June, 1964)

THE PROFESSIONAL STATUS OF NURSING

The author discusses the four basic structural components which E. C. Hughes thinks distinguishes a profession from an occupation. He presents the four dilemmas of nursing as the patient-care versus patient-care-administration, the degree of autonomy in which the profession works, the great change in the image and expectations nurses hold of the nursing profession, and nursing education. He proceeds to describe each. The author concludes by stating the reasons why the nursing profession must define its specific goals, teach the public what they mean by professionalism, and imbed a true image of the professional nurse.

(Ralph H. Meyer, "Professional Status of Nursing," Hospital Topics, 42: 35, May, 1964)

GUIDELINES FOR CONSTRUCTION OF NURSING SCHOOLS

Planning considerations relating to the establishment of new nursing educational facilities or the expansion of existing schools are given in a joint committee report released today by the National League for Nursing and the Public Health Service, Department of Health, Education, and Welfare.

The report, "Nursing Education Facilities: Programming Considerations and Architectural Guide," is the work of a 14-member Joint Committee of the National League for Nursing and the Public Health Service.

The 88-page document presents a comprehensive picture of facility needs as related to four types of nursing education programs. These are the diploma and practical nursing programs, the associate degree program, and the collegiate programs at the baccalaureate and graduate levels.

(Public Health Service News Release, U. S. Department of Health, Education, and Welfare, July 30, 1964)

THE LAW AND THE PRIVATE DUTY NURSE

The author states the private duty nurse is responsible for her own negligent acts, is not eligible for workmen's compensation, and rarely has a "legal right" to practice in a given hospital. The relationship between the hospital and the private duty nurse has some similarities to that between the hospital and members of the medical staff. These similarities are most noticeable when the hospital restricts the activities of the private duty nurse in the hospital, or forbids her to practice there. The author presents several court decisions to support this statement.

(Nathan Hershey, "The Private Duty Nurse," American Journal of Nursing, 64: 121, May, 1964)

ADMISSION AS A NURSING PROCEDURE

The article stresses the need for making the admission procedure less of a routine task and points out the importance of making it a therapeutic one and thereby establishing a relationship with the patient and the role of the nurse in achieving this relationship. Also described are the results of a study conducted in a large university hospital to test the validity that patient-centered nursing during

admission would produce more positive effects.

(Roslyn R. Elms, R. N., M. S. N., and Donna K. Diers, R. N., B. S. N., "The Patient Comes to the Hospital," Nursing Forum, II: 89, 1963)

NURSING EDUCATION FOR THE FUTURE

The characteristics of technical and professional education and the performance to be expected of the graduates of these programs are described. The author states, however, that it is true that in neither field of education—technical nor professional—are instructional programs consistently achieving these results. The author believes that despite present uncertainty and confusion, the nursing profession must come to an understanding regarding the desired nature of both nursing education and nursing practice.

(Mary S. Tschudin, B. S., Ph.D., "Educational Preparation Needed by the Nurse in the Future," Nursing Outlook, 12: 32, April, 1964)

CHANGING ANA TO MEET CHANGING NEEDS

This is a series of three articles which attempts to take a critical look at the functions of the ANA, and the mechanisms needed within the organization to carry them out. Part I: Appraising the Situation—focuses on ideas behind the proposed changes suggested in the structure of the association. Part II: Concern With Practice—outlines rearrangements which will enable ANA to focus on the growing interest and identification of nurses with special areas of practice. (The Study Committee on the Functions of ANA, which is presenting the proposals, believes this is "imperative and urgent," and suggests the creation of ANA Specialty Divisions to achieve it.) Part III: Resolving Complex Problems—in order to cope better with some of the serious questions facing nursing in the areas of economic and general welfare, nursing education, and nursing services, the Study Committee on the Functions of AMA has proposed the creation of three national commissions within the association. How these commissions would function and the needs for them are described in this third in a series.

(American Journal of Nursing, Part I: 64: 111, March, 1964; Part II: 64: 113, April, 1964; Part III: 64: 117, May, 1964)

NURSING COURSES INCLUDED IN NEW KELLOGG-AHA PLAN

The W. K. Kellogg Foundation will finance the newly formed "Partnership for Progress" of the American Hospital Association and other agencies and universities. The purpose of the five-year grant of $1,306,970 is to sharpen skills of hospital personnel through communication of up-to-date knowledge. There will also be a home study course directed to the increase of nursing management skills, patterned somewhat after the foundation-assisted program for hospital nursing unit supervisory personnel as conducted for the past four years by the Canadian Hospital Association and the Canadian Nurses Association. Each series of lessons will deal with a particular type of administrative skill commonly required by those at a given nursing management level.

(American Journal of Nursing, "Nursing Courses Included in New Kellogg-AHA Plan," 64: 30, April, 1964)

BOARDS OF REVIEW RELEASE NEW ACCREDITATION FIGURES

Following the spring meetings of the boards of review, programs in nursing education ac-

(Please turn to Page 116)

around the state

Candid Camera At





Medical Progress Assembly

Birmingham, Ala.








BREAK









credited by NLN now number:

Masters programs	35
Baccalaureate programs	143
Programs admitting students with no previous preparation in nursing and R.N. students from associate degree and diploma programs	72
Programs admitting only students with no previous preparation in nursing	60
Programs admitting only R.N. students	8
Programs admitting only R.N. students to a major in a specialized area of nursing	3
Associate Degree programs	5
Diploma Programs	571

(National League for Nursing News, July-August, 1964, 12: 6)

REQUEST FORM

Copies of the following articles are available. Please check the ones which you would like to receive:

- ☐ THE NEW DIPLOMA SCHOOLS 110
- ☐ ASSOCIATE DEGREE EDUCATION 110
- ☐ BACCALAUREATE EDUCATION 111
- ☐ ROLE OF ANA AND NLN IN STATE BOARD TEST POOL EXAMINATIONS 111
- ☐ INTERACTION IN THE OPERATING ROOM 111
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Mail to:

Department of Nursing
American Medical Association
535 North Dearborn Street
Chicago 10, Illinois

Alabama Department of Public Health

Alabama Water Improvement Commission Responsibilities, Activities and Accomplishments

Ira L. Myers, M. D., State Health Officer
Chairman, Water Improvement Commission

Federal and State Roles in Water Pollution Control

The Commission contends that full authority over intrastate control of water pollution should and must be vested in the states and that the federal government should not become involved. On the other hand, the Commission feels that the federal government should have enforcement powers over the pollution of interstate waters where the health and welfare of the citizens of a state are affected by pollution discharged within another state.

The federal government contributes to the over-all control of water pollution by investigations and research of the various aspects of water pollution and related problems. The federal government provides special laboratory services and consultation on unusual problems.

To a large degree the outstanding progress in the construction of municipal sewage treatment works in Alabama since 1956 can be credited to federal grant programs. Records reveal that 96 municipal projects in Alabama costing an estimated $54,707,746 have been federally assisted to the extent of $14,872,450. In addition, 12 Alabama municipalities have received grants under the Accelerated Public Works Program totaling $1,277,369 for the construction of collecting sewers.

Water Quality Conditions In Alabama

The comprehensive study of pollution of all streams and tributaries in Alabama conducted by the Commission during 1948 and 1949 provides an excellent baseline on which comparisons may be made. The 1948-1949 studies revealed these waters to be in good sanitary condition with few exceptions. Municipalities of the Tennessee River Basin were then discharging untreated sewage which created unsatisfactory conditions particularly at Athens and Huntsville where the flows of the recieving streams were extremely low. Municipalities along the Tennessee River lakes were found to contribute bacteria in numbers which affected recreational activity. The Mobile River and portions of Mobile Bay immediately adjacent to the cities of Mobile, Prichard, and Chickasaw were affected by bacteria contained in untreated or partially treated sewage. The Warrior River basin contained the most highly polluted areas within the State. These highly polluted areas are Five Mile and Valley Creeks from the City of Birmingham to their junctions with the Warrior River, Village Creek above Bayview Lake, and the Warrior River below Tuscaloosa. Choccolocco Creek was found to be grossly polluted by untreated sewage from the Anniston area and Black Creek. The Coosa River in the Gadsden area was in questionable condition due to untreated sew-

age and industrial waste. Dye, Shirtee, and Tallaseehatchee Creeks in the Coosa River basin were contaminated by industrial waste. Autauga and Catoma Creeks in the Alabama River basin were polluted by untreated sewage from Prattville and Montgomery, respectively. Pepperell Branch and Sougahatchee Creek in the Tallapoosa River basin were found to be heavily polluted by industrial waste. Untreated sewage from Auburn created problems in Parkerson Mill and Wrights Mill Creeks of this basin.

Since the discharge of untreated and partially treated sewage constituted the most widespread problem of pollution of 1949, a comparison of the status of sewage treatment in 1949 and 1964 is appropriate. The number of municipalities providing adequate treatment facilities has increased from 26 in 1949 to 98 in 1964. Municipalities providing inadequate or no treatment of sewage in 1964, are, for the most part, small in population, and the effects on receiving waters from these wastes are of a local nuisance character. Because of the larger cities in the Tennessee River basin this area deserves special mention. All major municipalities in this basin, with one exception, provide adequate treatment facilities. At this time plans and specifications for sewage treatment from this last major city are undergoing review. Other basins showing notable progress in sewage treatment are the Warrior, Coosa, Alabama, Mobile, Perdido, Choctawhatchee, and Conecuh. Areas in which problems of some magnitude are being experienced because of the lack of adequate sewage treatment are on the Warrior River at Cordova, Little Cahaba River at Trussville, and the Chattahoochee River in the Lanett area where bacterial concentrations are usually high and public water supplies and recreational areas could be affected.

In 1949 severe pollution from industrial sources was limited to Five Mile and Valley Creeks in Jefferson County, the Warrior River at and below Tuscaloosa, Pepperell Branch and Sougahatchee Creek in the Tallapoosa River basin, the Coosa River and Black Creek at and below Gadsden, Dye Creek in St. Clair County, and Shirtee and Tallaseehatchee Creeks in Talladega County. With the exception of Dye Creek from which the source of industrial waste creating a problem in 1949 has been removed, these areas are still severely polluted by industrial wastes.

Although there has been a considerable increase in industrial activity over the entire state since 1949 and industries have located in areas and on streams where none existed before, no significant problems due to these sources of waste have developed.

The Mobile River within the harbor area and for a distance of five miles upstream from its mouth together with Chickasaw Creek for a distance of two miles above its junction with the Mobile River has been defined as an area in which a minimum dissolved oxygen concentration of 2.0 parts per million will be accepted. This decision was reached by the Commission after a thorough evaluation of the problems encountered and a determination that the public interest would not be compromised by such a decision. This concentration of dissolved oxygen will permit fish to travel up the Mobile River and will not interfere with other uses of the waters.

The situation in the Warrior River at Tuscaloosa has been improved through the construction of sewage treatment plants by Northport and Tuscaloosa and the construction of Lake Smith on the Sipsey Fork. The construction and operation of this lake as a storage reservoir to supply water for a hydroelectric plant has increased the normal low flow in the Warrior River significantly. The dilution afforded by an increase of about ten times the low flow of the river at Tuscaloosa has undoubtedly improved conditions in the river, although the degree is yet to be determined by water quality surveys.

Note: The final article which summarizes the status of pollution control in Alabama and offers approaches to more effective water pollution control will appear in next month's issue.

BUREAU OF LABORATORIES

Thomas S. Hosty, Ph.D., Director

August 1964

Examinations for intestinal parasites	1,451
Typhoid cultures (blood, feces, urine and other)	237
Brucella cultures	0
Examinations for malaria	4
Examinations for gonococci	1,830
Serologic tests for syphilis (blood and spinal fluid)	23,122
Darkfield examinations	3
Agglutination Tests	1
Examinations for diphtheria bacilli and Vincent's	34
Complement fixation tests	45
Examinations for Negri bodies (smears and animal inoculations)	238
Water examinations	3,104
Milk and dairy products examinations	3,602
Examinations for tubercle bacilli	3,512
Miscellaneous examinations	3,930
Total	41,113

BUREAU OF PREVENTABLE DISEASES

W. H. Y. Smith, M. D., Director

CURRENT MORBIDITY STATISTICS

1964

	July	August	*E. E. August
Tuberculosis	93	134	176
Syphilis	241	148	144
Gonorrhea	420	453	387
Chancroid	0	5	3
Typhoid fever	1	0	3
Undulant fever	0	1	1
Amebic dysentery	4	8	4
Scarlet fever & strep. throat	136	212	27
Diphtheria	1	0	2
Whooping cough	23	19	20
Meningitis	11	4	9
Tularemia	0	0	0
Tetanus	0	1	2
Poliomyelitis	0	0	14
Encephalitis	0	1	1
Smallpox	0	0	0
Measles	261	64	29
Chickenpox	10	7	3
Mumps	19	35	20
Infectious hepatitis	78	36	29
Typhus fever	1	1	1
Malaria	0	0	0
Cancer	771	739	608
Pellagra	0	1	0
Rheumatic fever	17	15	9
Rheumatic heart	11	22	22
Influenza	19	9	30
Pneumonia	187	165	125
Rabies—Human cases	0	0	0
Pos. animal heads	0	1	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

BUREAU OF VITAL STATISTICS

Ralph W. Roberts, M. S., Director

PROVISIONAL BIRTH AND DEATH STATISTICS AND COMPARATIVE DATA, JULY 1964

Live Births / Deaths / Causes of Death	Number Registered During July 1964			Rates* (Annual Basis)		
	Total	White	Non-White	1964	1963	1962
Live Births	6,900	4,298	2,602	23.9	23.0	24.0
Deaths	2,507	1,605	902	8.7	8.5	9.0
Fetal Deaths	146	59	87	20.7	22.3	21.6
Infant Deaths—						
under one month	155	88	67	22.5	22.6	18.4
under one year	196	98	98	28.4	29.8	25.5
Maternal Deaths	2	1	1	2.8	11.9	7.3
Causes of Death						
Tuberculosis, 001-019	16	10	6	5.5	7.3	8.9
Syphilis, 020-029					1.0	2.1
Dysentery, 045-048	1		1	0.3	0.7	1.4
Diphtheria, 055						
Whooping cough, 056	1	1		0.3		0.4
Meningococcal infections, 057	1		1	0.3	0.7	0.4
Poliomyelitis, 080, 081						
Measles, 085						
Malignant neoplasms, 140-205	322	228	94	111.6	114.2	129.0
Diabetes mellitus, 260	42	27	15	14.6	16.4	11.4
Pellagra, 281						
Vascular lesions of central nervous system, 330-334	337	211	126	116.8	112.8	126.8
Rheumatic fever, 400-402	1		1	0.3	0.3	0.4
Diseases of the heart, 410-443	823	561	262	285.4	272.7	315.3
Hypertension with heart disease, 440-443	111	43	68	38.5	45.4	54.9
Diseases of the arteries, 450-456	65	40	25	22.5	15.7	18.5
Influenza, 480-483	4	3	1	1.4	0.7	1.4
Pneumonia, all forms, 490-493	55	33	22	19.1	22.3	21.0
Bronchitis, 500-502	3	2	1	1.0	1.4	1.1
Appendicitis, 550-553	3	2	1	1.0	1.0	0.7
Intestinal obstruction and hernia, 560, 561, 570	15	10	5	5.2	3.1	2.8
Gastro-enteritis and colitis, under 2, 571.0, 764	11	2	9	3.8	2.8	4.3
Cirrhosis of liver, 581	15	13	2	5.2	5.6	5.0
Diseases of pregnancy and childbirth, 640-689	2	1	1	2.8	11.9	7.3
Congenital malformations, 750-759	31	18	13	4.5	4.5	3.4
Immaturity at birth, 774-776	41	21	20	5.9	7.1	5.0
Accidents, total, 800-962	194	131	63	67.3	69.5	62.7
Motor vehicle accidents, 810-835, 960	99	78	21	34.3	37.7	26.7
All other defined causes	387	240	147	134.2	131.0	127.2
Ill-defined and unknown causes, 780-793, 795	137	51	86	47.5	38.8	37.4

*Rates: Birth and death—per 1,000 population
Infant deaths—per 1,000 live births
Fetal deaths—per 1,000 deliveries
Maternal deaths—per 10,000 deliveries
Deaths from specified causes—per 100,000 population

The Woman's Auxiliary



Dear Doctors:

Have you heard about the "civic wallflowers?" "Civic Wallflowers" are unconcerned, uninformed, uninterested, and unlikely to vote. I have stolen the term and the definition from AMPAC's new Precinct Action Course Handbook. The Handbook goes on to state that whichever side reaches them, extends a friendly hand, asks for their vote, and shepherds them through registration and to the polls is most likely to get their support. I would hate to think that anyone in the medical family would fit the last part of the definition but I wonder if any of us are unconcerned, uninformed, uninterested, and unlikely to vote.

I have been anxiously awaiting AMPAC's Precinct Action Course because from the time I heard about it in San Francisco, it sounded like the practical politics my family practiced. As a life-long Democrat, and one of the few connected with the medical profession left in the State of Alabama, I hated to give up my party because it had become the prisoner of a harder working group. In a way I hate to tip off all you Republicans on how to get out the votes to win elections. This is AMPAC's Precinct Action Course which can be ordered for $15.00 from:

A M P A C
520 North Michigan Avenue
Chicago, Illinois 60611

If doctors and their wives, on the local level, would follow the steps outlined, it would save us a lot of letter writing and telegrams. We would know that we had elected members of Congress who would vote their convictions, because they are the same as ours, and would not worry about re-election because they would know they have active party workers behind them.

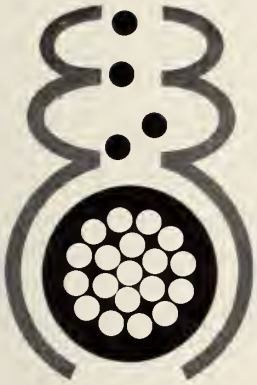
This is the end of the "sales-pitch." Are you registered, is your wife registered, is your son or daughter who has just turned 21 registered? Let's vote, let's see to it that our friends vote. The swing vote, the vote of people who are not party members and workers, is the one that carries the election. In this day and time we cannot afford not to have ulterior motives when we vote. An incumbent who believes as you do and has a satisfactory voting record in Congress, will have more power than a "freshman." A "freshman" from the majority party will fare better than a "freshman" from the minority party. Know your candidate, be familiar with his voting record, and, most important of all, work for him between now and election day in November.

We should be interested in politics on the state level too. Alabama is unique in that the Medical Association of the State of Alabama is also the State Board of Health. We need to protect the health and well-being of our people and be sure that the Legislature never takes this unique protection away from them.

Time is short. Be sure that you and your family are registered with poll-tax paid. Be sure all members of your family vote. Check up on your friends.

See you at the polls,

Frances Clemmons



LOMOTIL®

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride . . . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate . . . . . 0.025 mg.

- lowers motility promptly
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- stops diarrhea promptly

Lomotil fulfills the first order of treatment in most patients with diarrhea — prompt symptomatic control.

Pending discovery of the cause, early cessation of diarrhea is almost always urgently indicated. Prompt symptomatic control averts distress, dehydration and, frequently, severe exhaustion.

Both experimental and clinical evidence indicates that Lomotil exerts such control efficiently, safely and with maximal promptness.

dosage:

The recommended initial *adult* dosage is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is controlled. Maintenance dosage may be as low as two tablets daily. *Children's* daily dosage (in divided doses) varies from 3 mg. for a child of 3 to 6 months, to 10 mg. for one 8 to 12 years of age.

cautions and side effects:

Lomotil is an exempt narcotic; its abuse liability is low and comparable to that of codeine. Recommended dosages should not be exceeded. Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates.

Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

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Effective in controlling tetracycline-sensitive bacterial infection and providing symptomatic relief in allergic diseases of the upper respiratory tract. Possible side effects are drowsiness, slight gastric distress, overgrowth of nonsusceptible organisms. Tooth discoloration may occur only if the drug is given during tooth formation (late pregnancy, the neonatal period, early childhood). Reduce dosage in impaired renal function. Average Adult Dosage: 2 Tablets four times daily.

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Side Effects: Occasionally, mild salicylism may occur, but it responds readily to adjustment of dosage. Precaution: In the presence of severe renal impairment, care should be taken to avoid accumulation of salicylate and PABA. Contraindicated: An hypersensitivity to any component.

Also available: PABALATE—when sodium salts are permissible. PABALATE-HC—Pabalate-SF with hydrocortisone.

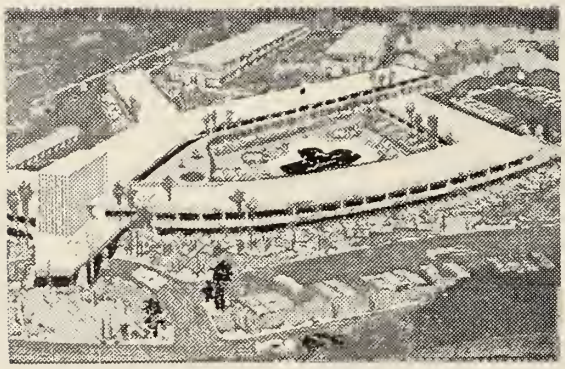
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In Sprains, Strains and Muscle Spasm, 'Soma' Compound

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2. A.P.C. compounds have limited usefulness; and the patient can buy them without your prescription. Unfortunately, most of them are too mild to be effective for sprains—and more potent products too often make the patient feel 'dopey'.

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5. Hypersensitivity to carisoprodol may occur rarely. Codeine may produce addiction, nausea, vomiting, constipation or miosis.

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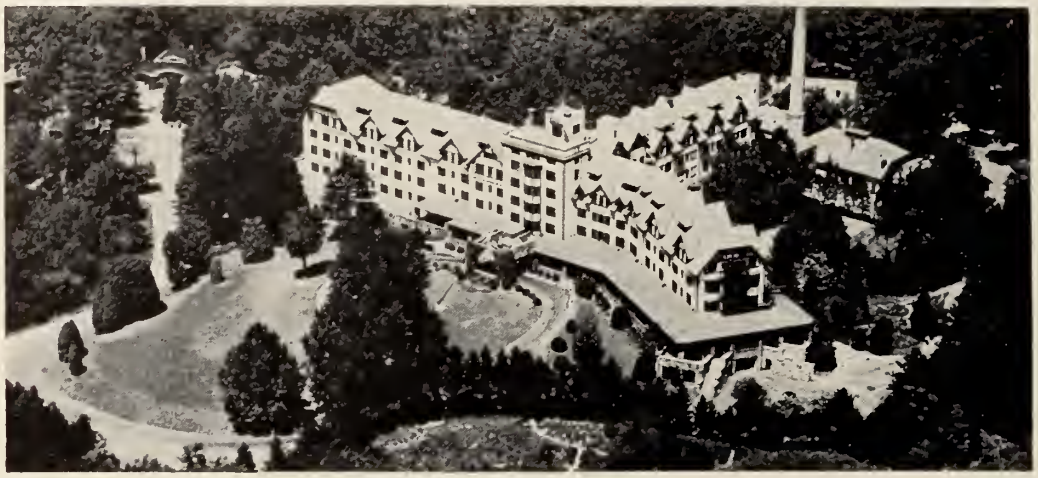
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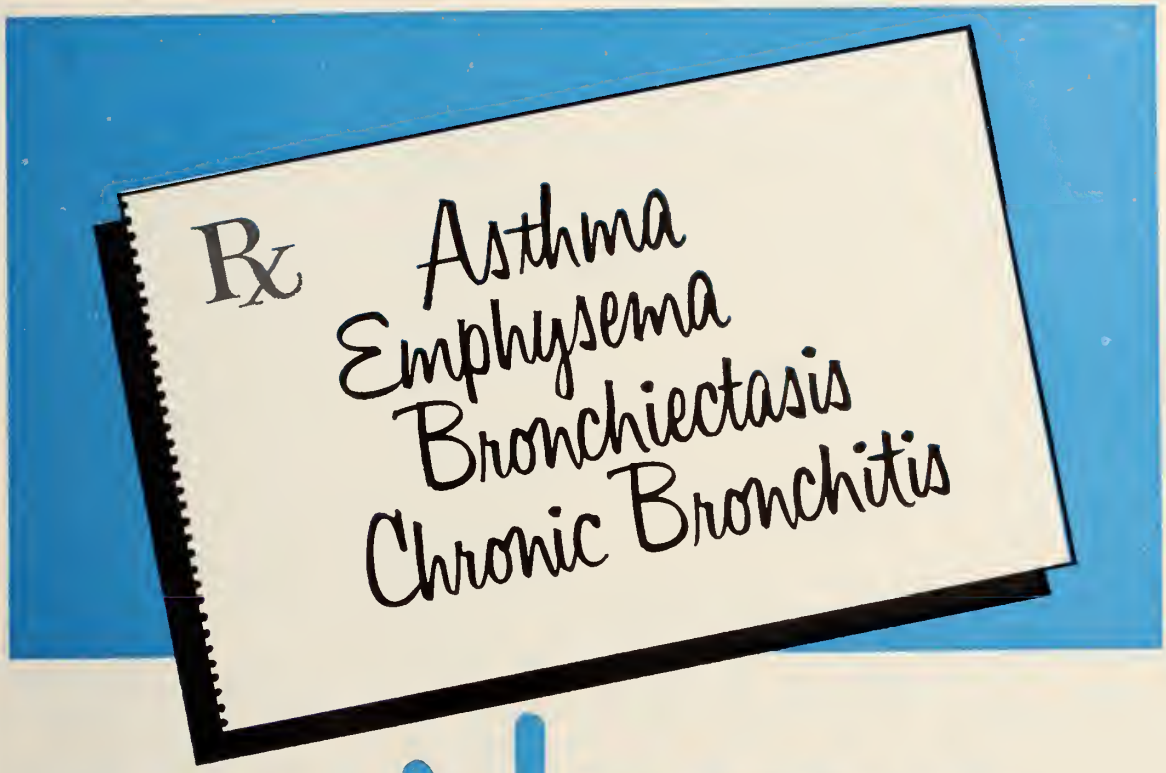
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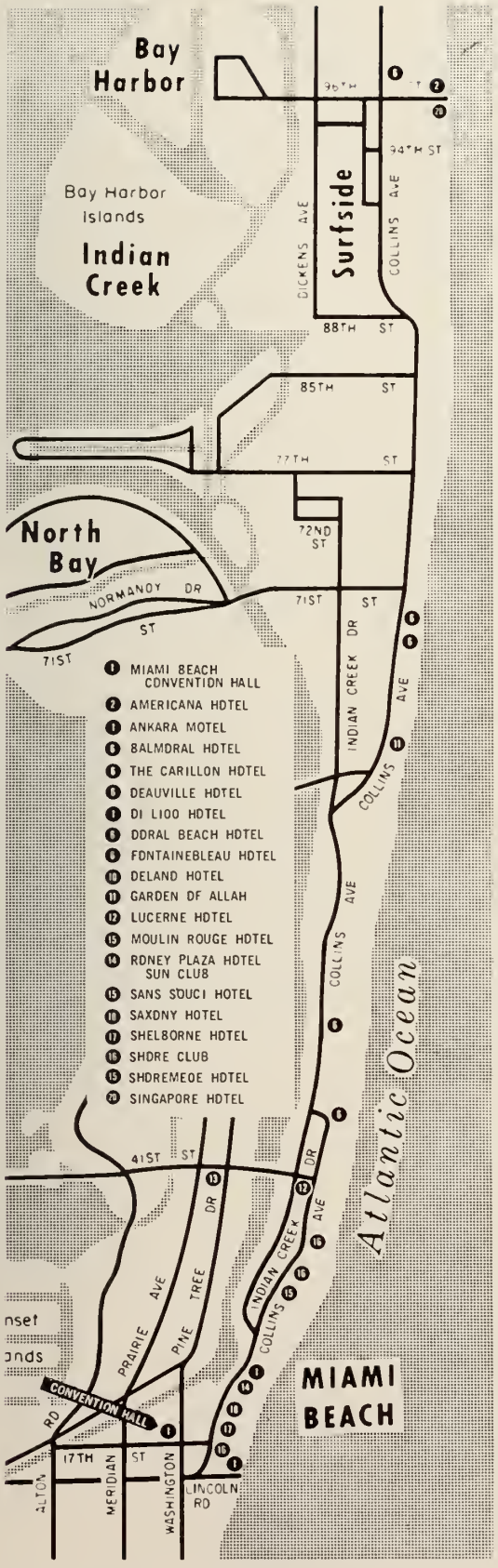
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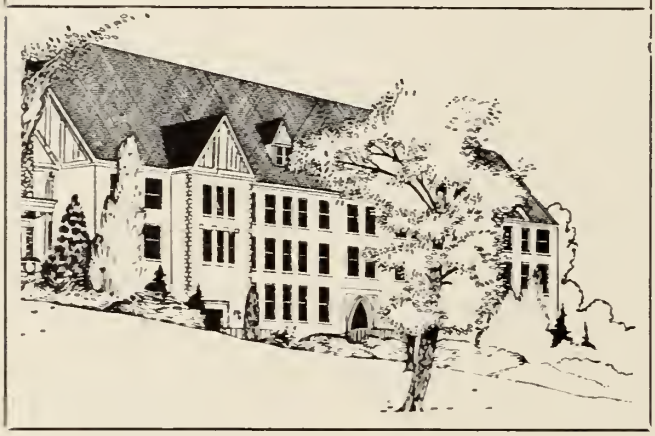
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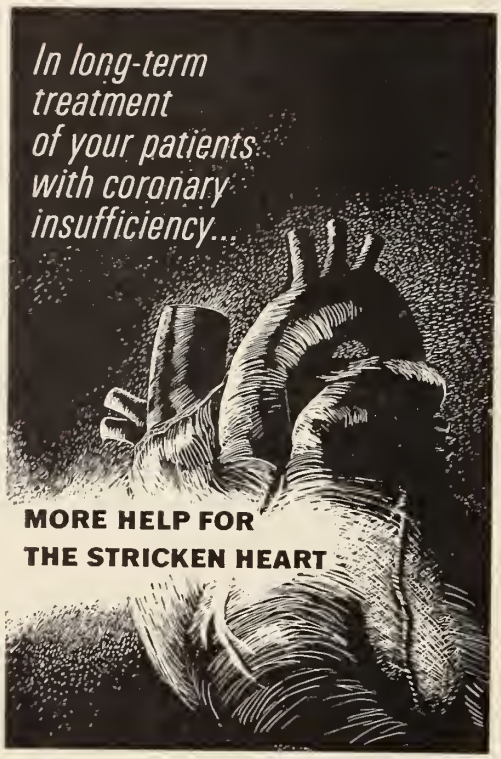
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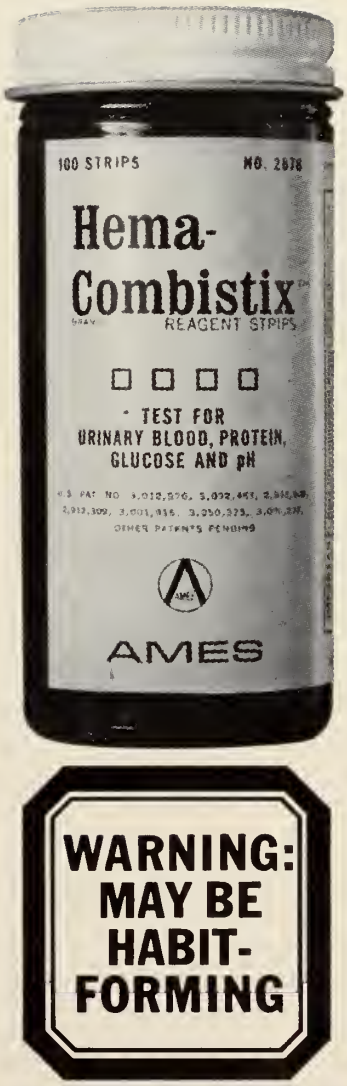
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Valium (diazepam) may also be useful in acute agitation due to alcohol withdrawal.

Valium (diazepam) may be of use to alleviate muscle spasm associated with cerebral palsy and athetosis.

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Muscle spasm associated with cerebral palsy or athetosis	2 mg to 10 mg, 3 or 4 times daily

Contraindications: Valium (diazepam) is contraindicated in infants, patients with a history of convulsive disorders or patients with a history of glaucoma.

Warning: Valium (diazepam) is not of value in dealing with psychotic patients manifesting anxiety and should be avoided when there is reason to believe the patient is psychotic.

Precautions: In elderly or debilitated patients, it is important to limit the dosage to the smallest effective amount to preclude the development of ataxia or oversedation (not more than 1 mg, 1 or 2 times daily initially, to be increased gradually as needed and tolerated). As is true of all CNS-acting drugs, until the correct maintenance dosage is established, patients receiving Valium (diazepam) should be advised against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving an automobile during the period of Valium (diazepam) therapy is not recommended. In general, the concurrent administration of Valium (diazepam) and other psychotropic agents is not recommended. If such combination therapy is used, careful consideration should be given to the pharmacology of the agents to be employed with Valium (diazepam)—particularly with known compounds which may potentiate the action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants.

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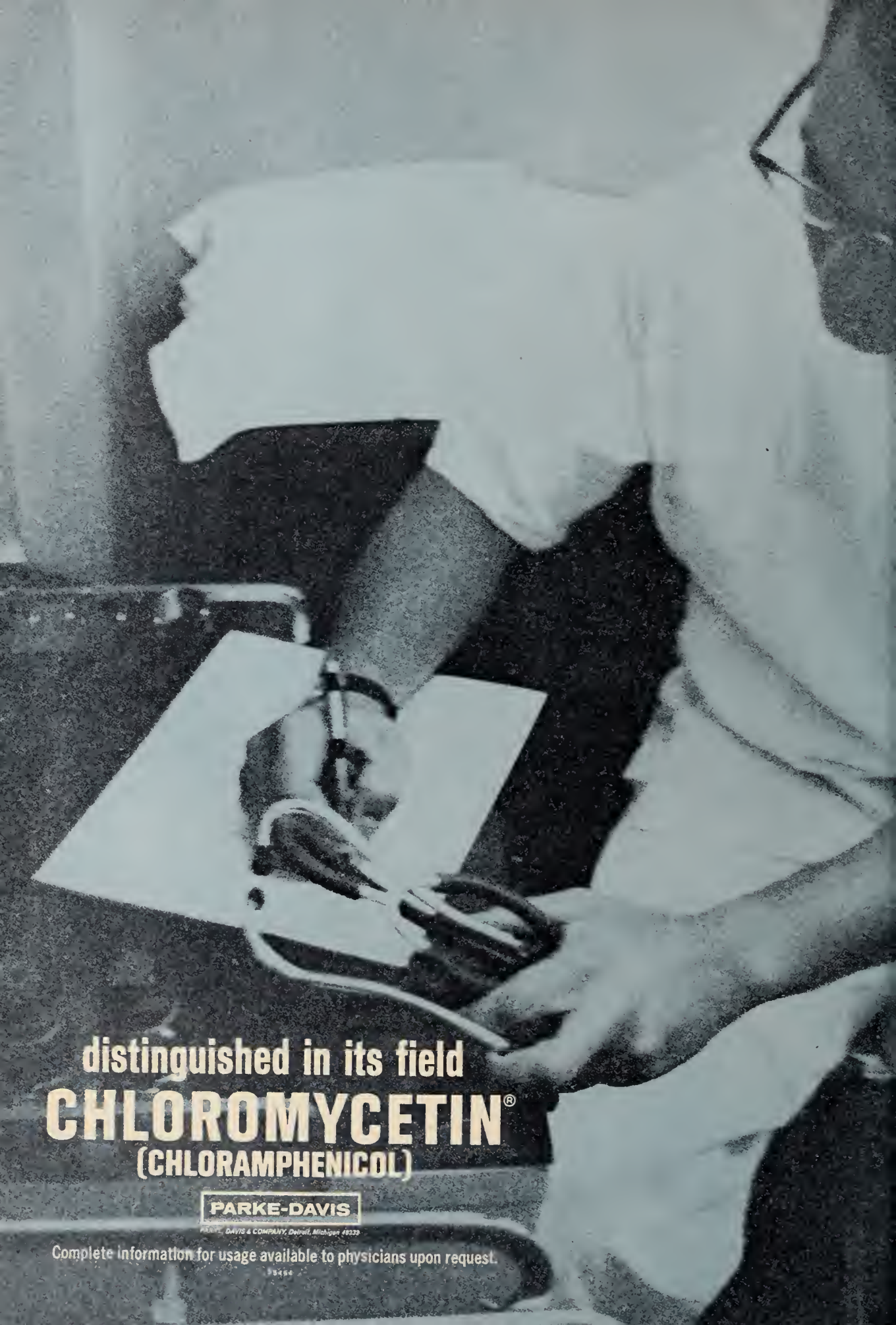
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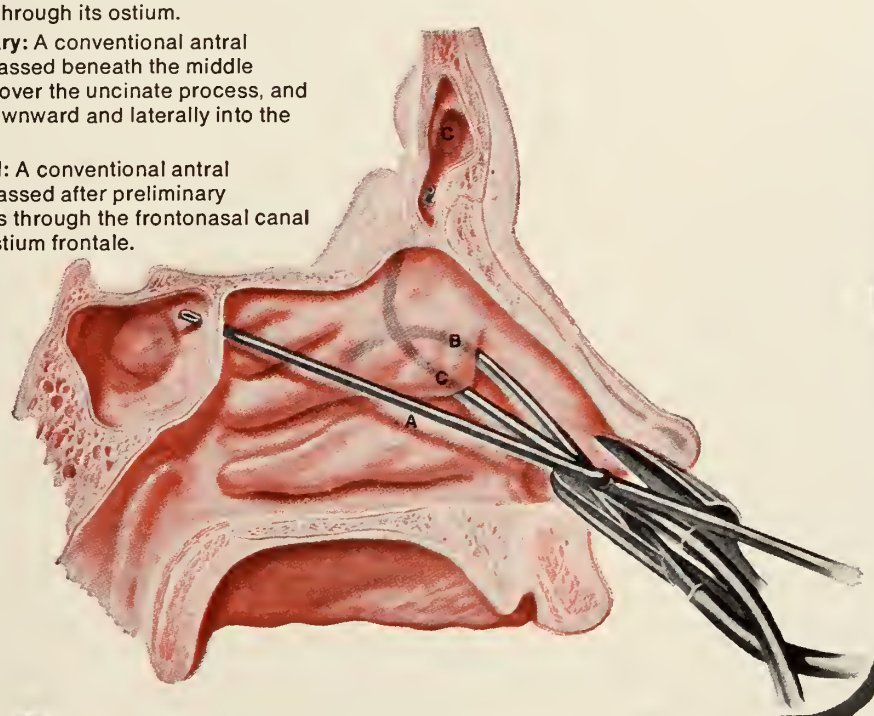
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A rhinologic approach to the sinuses
Sagittal anatomical section of nasal cavity showing approach for probing or irrigation by cannulas.

A—Sphenoid: A sphenoid cannula (under 13.5 cm.) passed around the middle and superior turbinates to the anterior wall of the sinus through its ostium.

B—Maxillary: A conventional antral cannula passed beneath the middle turbinate, over the uncinate process, and rotated downward and laterally into the ostium.

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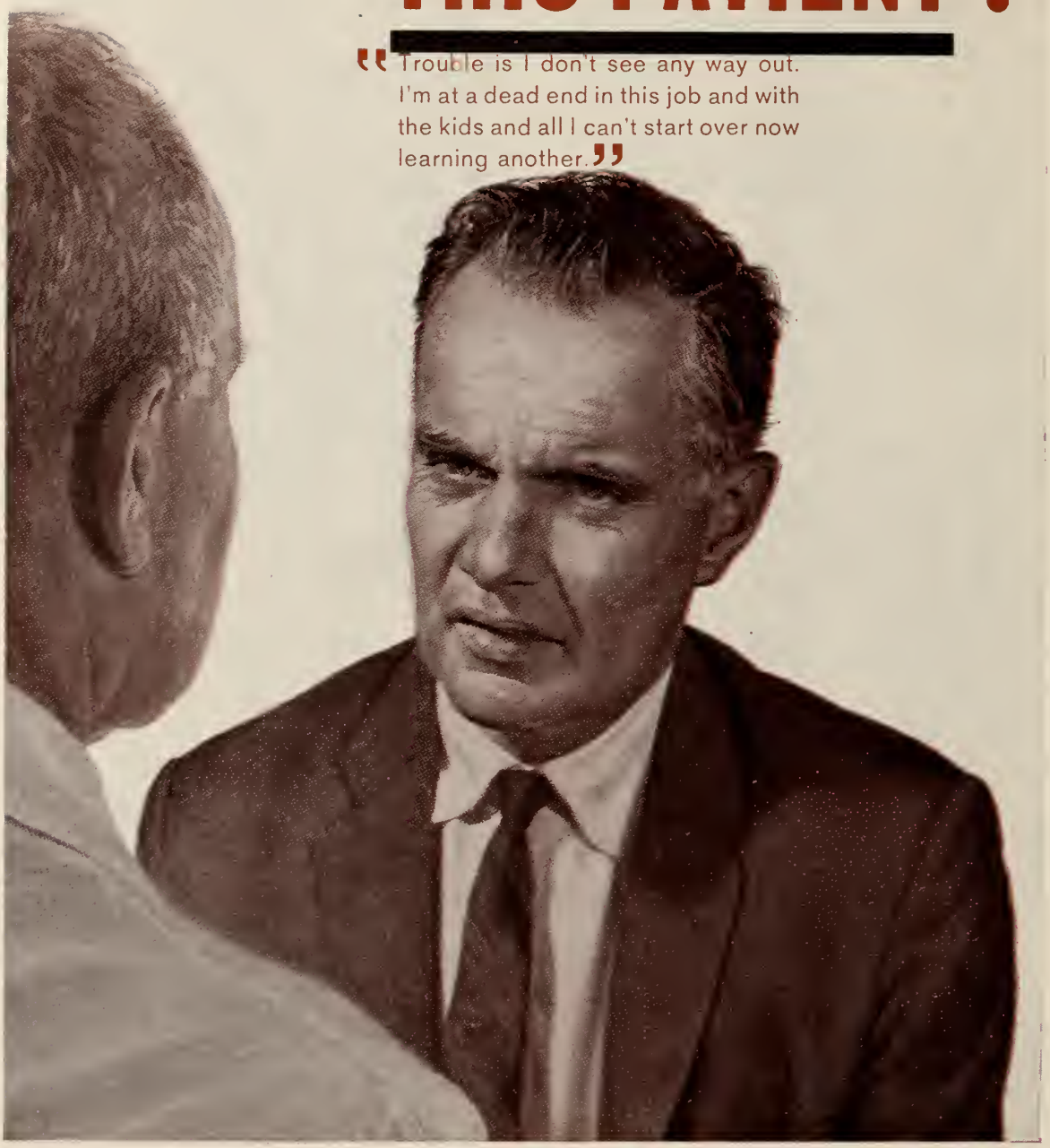
*Reed, G. F.: Sinusitis, New England J. Med. 267:402, Aug. 23, 1962.

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RECOGNIZE THIS PATIENT?



Indications: Depression, both acute (reactive) and chronic, especially when the depression is accompanied by anxiety, insomnia, and related symptoms. **Contraindications:** Benactyzine hydrochloride is contraindicated in glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use. **Precautions:** Should administration of meprobamate cause drowsiness or visual disturbances, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Prescribe cautiously and in small quantities to patients with suicidal tendencies. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal **Side effects:** Side effects associated with 'Deprol' have consisted primarily of drowsiness and occasional dizziness, and infrequent skin rash and nausea. *Benactyzine hydrochloride* – Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

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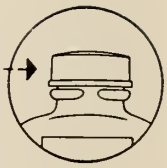
Meprobamate— Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses of the drug. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasm, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis, and anaphylaxis. Treatment should be symptomatic and the drug not reinstituted. Isolated cases of agranulocytosis and thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Massive overdosage may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. **Dosage:** Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and reduced gradually to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients. **Supplied:** Light-pink, scored tablets, each containing meprobamate 400 mg. and benactyzine hydrochloride 1 mg. *Before prescribing, consult package circular.*

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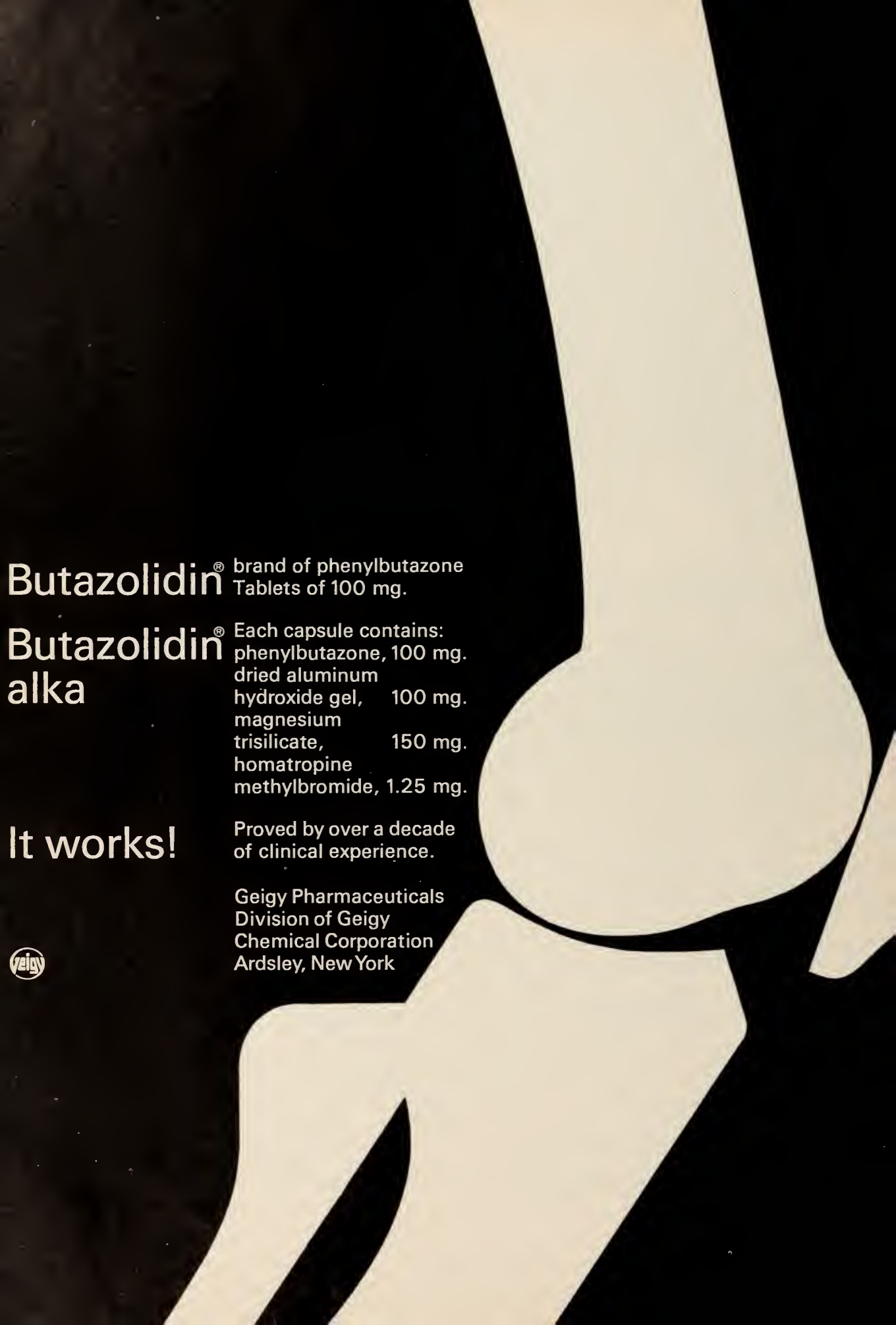
Research conducted at Eastman Dental Dispensary ranked soft drinks in the same category as cabbage, cucumbers, zwieback and egg noodles—foods having negligible cariogenic potential [1].

This study also indicated that the amount of carbohydrate in food is not as important as the length of time it is retained in the mouth. Sparkling soft drinks pass through the mouth quickly, leaving only pure, flavorful thirst-quenching refreshment.

(1) *Bibby, Basil G. D.M.D., PH.D., et al "Evaluation of Caries-Producing Potentialities of Various Foodstuffs" Jl of Am Dent Assn; vol 42, May '51, pps 491-509*

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Pheniramine maleate	7.5 mg.
Codeine phosphate	10.0 mg.

(Warning: may be habit forming)

Alcohol 3.5 per cent

Robitussin is indicated in coughs associated with head and chest colds, bronchitis, laryngitis, tracheitis, pharyngitis, pertussis, "flu," "grippe," measles, chronic paranasal sinusitis, pulmonary tuberculosis, or smoking. Robitussin A-C is especially indicated for allergic, harsh or unresponsive coughs.

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side effects: No serious side effects from glyceryl guaiacolate have ever been reported. Nausea, G-I upset, and drowsiness may be encountered rarely with Robitussin A-C.

precautions: There are no contraindications for Robitussin. Robitussin A-C is contraindicated in patients hypersensitive to antihistamines or codeine.

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Alcohol 3.5 per cent in a palatable, aromatic base.

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(exempt narcotic)

antihistaminic / antitussive / suppressant

Codeine phosphate	10 mg.

(Warning: may be habit forming)

Dimetane® (brompheniramine maleate)	2 mg.
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Phenylpropanolamine hydrochloride	5 mg.
Glyceryl guaiacolate	100 mg.

Alcohol 3.5 per cent in a palatable, aromatic base.

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Precautions: Administer with caution to patients with cardiac or peripheral vascular diseases and hypertension.

contraindications: Hypersensitivity to antihistamines or codeine. Not recommended for use during pregnancy.

references:* Boyd, E. M., and Ronan, A. K.: Am. J. Physiol., 135:383, 1942.



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rational combination therapy for sprains and strains: relaxes muscle, relieves pain. Also available with ¼ gr. codeine as 'SOMA' COMPOUND with CODEINE: carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning: may be habit-forming.)

BRIEF SUMMARY

'SOMA' COMPOUND; 'SOMA' COMPOUND plus CODEINE: carisoprodol, acetophenetidin, caffeine, codeine phosphate. *Warning: Codeine may be habit-forming.* **Indications:** 'Soma' Compound and 'Soma' Compound with Codeine are indicated for relief of pain and stiffness in traumatic, rheumatic and other similar conditions. **Contraindications:** Allergic or idiosyncratic reactions to carisoprodol or codeine. **Precautions:** *Acetophenetidin*—May damage the kidneys when used in large amounts or for long periods. *Codeine*—Should be used with caution in addiction-prone individuals. *Carisoprodol*—Like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate. **Side effects:** *Codeine*—Nausea, vomiting, constipation, and miosis. *Carisoprodol*—The only side effect reported with any frequency is drowsiness, usually on higher than recommended doses. One instance each of pancytopenia and leukopenia occurring when carisoprodol was administered with other drugs has been reported as has an instance of fixed drug eruption with carisoprodol and subsequent cross-reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. Other rarely observed reactions have included dizziness, ataxia, agitation, increase in eosinophil count, and gastrointestinal symptoms. Massive overdosage may produce coma and/or mild shock and respiratory depression. **Dosage:** 'Soma' Compound and 'Soma' Compound with Codeine, one or two tablets three times daily and at bedtime. **Supplied:** 'Soma' Compound, orange tablets, each containing carisoprodol 200 mg., acetophenetidin 160 mg., and caffeine 32 mg. 'Soma' Compound with Codeine, white, lozenge-shaped tablets, each containing carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., and codeine phosphate 16 mg. Narcotic order form required. *Before prescribing, consult package circular.*

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Cranbury, N. J.



Of 507 patients with confirmed ear, nose and throat infections... 465 or 91.7% were treated successfully with Signemycin®

Note:
Adams,* whose 50 patients included 20 with ENT infections, stated that Signemycin "was particularly valuable in infections that did not respond to other antimicrobial agents, and in patients to whom penicillin could not be given." All his cases responded within five days; in most patients, all signs of infection disappeared in three days.

*Adams, J.: J. Tenn. Med. Ass. 50:446, Nov., 1957.

Condition	No. of Patients	No. Cured with Signemycin
Otitis media	90	86
Pharyngitis and laryngitis	162	148
Sinusitis	68	55
Tonsillitis and peritonsillitis	163	153
Various	24	23
Totals	507	465 (91.7%)

consistently effective...often when others fail

Signemycin®

tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Also available as Syrup, Pediatric Drops, and half-strength Capsules

Brief Summary and Bibliography follow.

Science for the world's well-being® Pfizer *Since 1849*

PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc. New York, New York 10017



ACHROCIDIN®

TETRACYCLINE HCl-ANTIHISTAMINE-ANALGESIC COMPOUND

Each Tablet contains:	
ACHROMYCIN® Tetracycline HCl	125 mg.
Acetophenetidin (Phenacetin)	120 mg.
Caffeine	30 mg.
Salicylamide	150 mg.
Chlorothen Citrate	25 mg.

Each (5 cc.) Teaspoonful of Syrup (lemon-lime flavored) contains:	
ACHROMYCIN® Tetracycline equivalent to Tetracycline HCl	125 mg.
Acetophenetidin (Phenacetin)	120 mg.
Salicylamide	150 mg.
Ascorbic Acid (C)	25 mg.
Pyrilamine Maleate	15 mg.
Methylparaben 4 mg.; Propylparaben 1 mg.	

Effective in controlling tetracycline-sensitive bacterial infection and providing symptomatic relief in allergic diseases of the upper respiratory tract. Possible side effects are drowsiness, slight gastric distress, overgrowth of nonsusceptible organisms, tooth discoloration. The last named may occur only if the drug is given during tooth formation (late pregnancy, the neonatal period, early childhood). Average Adult Dosage: 2 Tablets or 2 Teaspoonfuls of Syrup four times daily. The total average daily dosage for children, determined by the tetracycline content, is 10 to 20 mg. per pound body weight, divided into four equal doses.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

7143-3

Lederle



Of 1,088 patients with confirmed skin and soft-tissue infections... 1,036 or 95.2% were treated successfully with Signemycin®

Note:
Morador et al.* obtained *excellent results in the treatment of 185 out of 191 soft-tissue infections,* all due to staphylococci. They state: "In the most serious infections occurring in patients with impaired resistance (mainly diabetics) we have had very good results in the control of the infectious condition." In these studies, incision and drainage were employed where indicated.

*Morador, J. L. et al.: Antibiot. Ann. 1959-1960:716.

Condition	No. of Patients	No. Cured with Signemycin
Abscesses, various	35	34
Abscess, gluteal or perianal	54	52
Burns, infected	331	307
Carbuncles and furuncles	125	122
Cellulitis	104	102
Lacerations and wounds, infected	142	128
Ulcers, infected	107	106
Various superficial infections	190	185
Totals	1,088	1,036 (95.2%)

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tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Also available as Syrup, Pediatric Drops, and half-strength Capsules

Brief Summary and Bibliography follow.

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SIGNEMYCIN®

Side Effects: Glossitis and allergic reactions, as well as severe anaphylactoid reactions, have been reported as rare side effects. Should significant reaction or idiosyncrasy occur, discontinue medication and institute countermeasures. Use of tetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. Reduce usual oral dosage and consider serum level determinations in patients with impaired renal function to prevent possible liver toxicity due to excessive accumulation of antibiotic in the serum.

Precautions: Overgrowth of nonsusceptible organisms may occur. In such cases, discontinue medication and institute appropriate specific therapy as indicated by susceptibility testing. Aluminum hydroxide gel given with antibiotics has been shown to decrease their absorption and is contraindicated. The coloring agents used in Signemycin Syrup and Pediatric Drops may produce red discoloration of stools.

Triacetyloleandomycin, a constituent of Signemycin, administered to adults in daily oral doses of 1.0 Gm. (3 Gm. Signemycin) for periods of more than ten days may produce hepatic dysfunction and jaundice. In the rare patient who requires this high dosage level of Signemycin initially, liver function should be carefully followed and dosage should be reduced, as promptly as possible, to the usual recommended range of 1.0 to 2.0 Gm. per day. Therefore, Signemycin is recommended primarily for the treatment of acute or severe infections, with treatment restricted to a ten-day period. If clinical judgment dictates continuation of therapy beyond ten days, serial monitoring of the liver profile should be carried out, including BSP, transaminase, and cephalin flocculation tests. Changes observed in liver function were reversible following discontinuation of the drug.

Formulas: Capsules: 250 mg. Signemycin (167 mg. tetracycline HCl and 83 mg. oleandomycin as triacetyloleandomycin).

Capsules: 125 mg. Signemycin (83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin).

Syrup: 125 mg. Signemycin (tetracycline equivalent to 83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin) per 5 cc.

Pediatric Drops: 100 mg. Signemycin (tetracycline equivalent to 67 mg. tetracycline HCl and 33 mg. oleandomycin as triacetyloleandomycin) per cc.

More detailed professional information available on request.

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Note:

The high rate of response to Signemycin in these cases is noteworthy because the totals include many patients with difficult-to-treat infections, many whose infections had proved resistant to other agents, and many who had been treatment failures on other therapy.[1-87] In addition the following criteria were used for the cases cited: (1) only published results were used (2) results were confirmed by clinical and/or laboratory findings (3) patients were cured, not "improved" (4) dosage conformed with current recommendations in the United States (5) no other anti-infective agents were used concomitantly (6) no instance of prophylactic use was included in these tabulations.

Condition	No. of Patients	No. Cured with Signemycin
Ear, nose and throat infections	507	465
Respiratory infections	1,028	954
Gastrointestinal infections	425	387
Genitourinary infections	748	684
Skin and soft-tissue infections	1,088	1,036
Bone and joint infections	71	64
Deep-seated or generalized infections	257	251
Obstetrical & gynecological infections	341	320
Miscellaneous conditions	592	570
Totals	5,057	4,731 (93.5%)

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tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

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and it's not a once-over-lightly one, either. All rubber stoppers used in Lilly ampoules are scrupulously cleaned with a detergent and hot deionized water in a special washing machine like the one pictured above. This removes any foreign matter adhering to them. Then the stoppers are autoclaved at 120° to 121°C. for one hour. They are now clean, sterile, and ready for use. In case the stoppers are not used within seventy-two hours, they are returned for resterilization. □ This meticulous process is only one of the many safeguards to insure the quality of the finished product and to protect the ultimate user.

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"MONITORING" IN THE MANAGEMENT OF INTESTINAL OBSTRUCTION

by
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At least 5 per cent of the fatalities from intestinal obstruction are due to inadequate preoperative preparation and can, therefore, be prevented by expeditious and adequate resuscitation.[1] In the case of an acute obstruction resuscitation time will be minimal, and the risk of infarcted intestine can be met head on by early laparotomy. In the patient with intestinal obstruction of over three days' duration, the risk of vascular embarrassment is usually minimal, but resuscitation will require time and judgment and offers our most fertile field for increasing patient survival.

Individual patient requirements and responses are determined by monitoring the cardiovascular, renal, and pulmonary systems. In Fig. 1 the monitored patient is depicted as having central venous, arterial, and urinary catheters. The central venous catheter is inserted via a peripheral vein to the level of the vena cava[2] and connects via a three-way stopcock to a venous manometer and the intravenous fluid; the arterial catheter is placed in the brachial artery[3] and patency is maintained by filling the tube with heparin solution* after each arterial sample is withdrawn for gas analyses; the urinary catheter is connected to a calibrated collection burette. Periodic urine volume measurement (Fig. 2) is essential in replacement therapy; however, other studies, such as

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*1 cc. of 10,000 units/cc. heparin to 1000 cc. N/S.

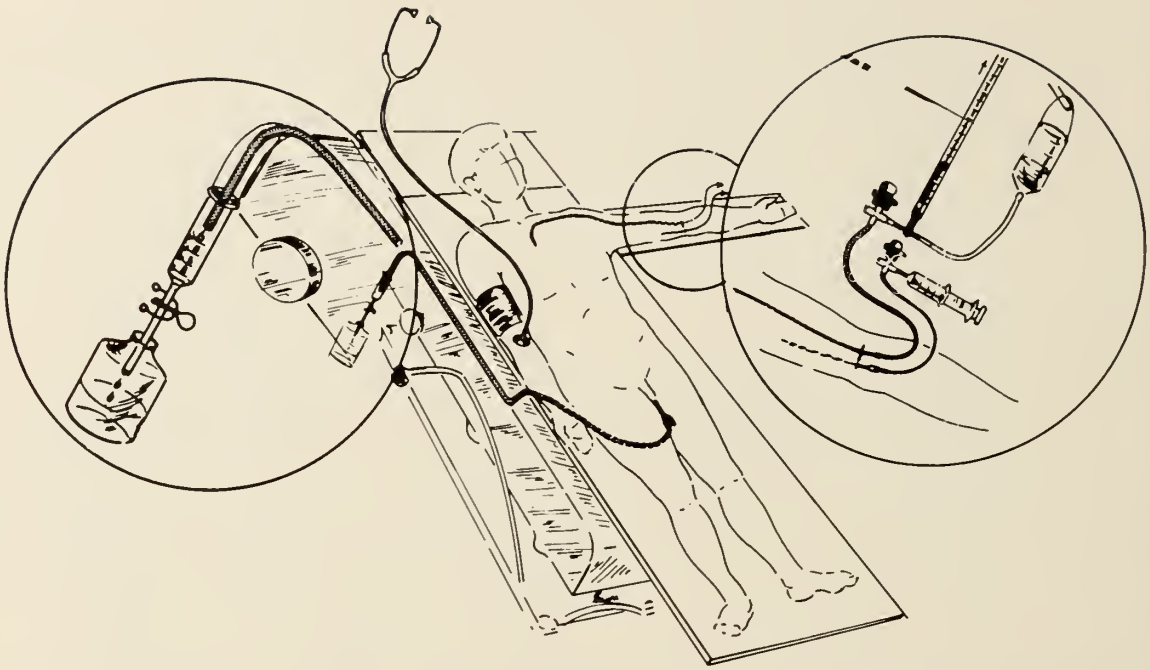


Fig. 1. The above figure shows a urinary catheter connected to a drip chamber, a central venous catheter connected through a three-way stopcock to venous manometer and intravenous fluid, and an arterial catheter from which blood samples can be obtained.

urine to plasma creatinine or urea nitrogen ratios, may be necessary for the diagnosis of tubular necrosis should this condition become suspect.

By presenting the monitoring techniques we do not mean to minimize or neglect more commonly used signs of patient response such as capillary perfusion, longitudinal tongue furrowing, precordial heave, and other general and local physical signs reflecting the progress of the disease process. For the sake of brevity we will assume that all of these factors will be observed and considered in the management program. That they cannot be specifically defined in each case is adequate testimony to the continued need for physicians at the bedside.

The role and value of electrolyte determinations are apparent. It is impossible to predict the acid-base balance of a given patient on the basis of duration of obstruction, suspected level of obstruction, amount of vomitus, or character of vomitus. Whereas the patient with vomiting will frequently have hypochloremic alkalosis, this is not always true, and the only definitive measurement is the blood pH. Although the patient with metabolic acidosis usually requires a greater volume of fluid than the patient with alkalosis, this fluid may be less well accepted because of poor myocardial function in the acidotic state. Correction of the acidosis may, therefore, be the essential first step.

In order to exemplify the utility of "monitoring" we will now discuss the monitored systems with reference to the debilitated patient or the patient who has failed to respond to what the p h y s i c i a n anticipated would be adequate and appropriate replacement therapy. Fig. 3 lists the cardiovascular functions monitored and the basic components reflected in each function. The central venous pressure serves the dual purpose of warning against vascular space overload with

RENAL SYSTEM

I. URINE VOLUME
- (1.) Renal blood flow
- (2.) Glomerular function
- (3.) Tubular function

II. URINE CONCENTRATION
- (1.) Tubular function

Fig. 2. Determinations and functions identified via the urinary catheter.

elevated pressure (greater than 150 mm. H_2O) and of suggesting inadequate replacement with lower pressures (less than 50 mm. H_2O). Resuscitation may require six, eight, or ten liters of electrolyte solution before adequate tissue perfusion and urine output can be achieved. Consequently, rapid electrolyte replacement could not be completed without the assurance of an adequate cardiac response as reflected by a stable central venous pressure. The patient with an elevated or rapidly rising venous pressure in the face of clinical dehydration or inadequate tissue perfusion is identified as having an inadequate cardiac reserve and needs correction of acidosis and/or digitalization. A low central venous pressure is important in the oliguric patient when one is differentiating oliguria of dehydration from oliguria of tubular necrosis or as an indication for the administration of an osmotic diuretic such as mannitol.

Further discussion of pulse and blood pressure is not necessary; however, one should make every effort to achieve a normal pressure and pulse without vasopressors as these agents may protect certain vital circulations temporarily,[4] but the resultant peripheral constriction may contribute to a decreased tissue perfusion and metabolic acidosis.

CARDIOVASCULAR SYSTEM

I. BLOOD PRESSURE
- (1.) Left ventricular output
- (2.) Blood volume
- (3.) Peripheral resistance

II. PULSE
- (1.) Cardiac integrity

III. CENTRAL VENOUS PRESSURE
- (1.) Effective blood volume
- (2.) Right ventricular competency

Fig. 3. Determinations and functions identified via the blood pressure, pulse, and central venous pressure.

RESPIRATORY SYSTEM

pO_2 Oxygenation
pCO_2 Ventilation
pH Acid-Base Balance
> Pulmonary Function

Fig. 4. Determinations and functions identified via the arterial catheter and the blood gas analyses.

Fig. 4 shows the functions determined from arterial blood on the Beckman Model 160 physiological gas analyzer.[5] Hypoxia and acid-base problems are not only common in obstruction but, as previously stated, are difficult to identify without these direct measurements and may be critical in the pulmonary or cardiac cripple. Most of us be-

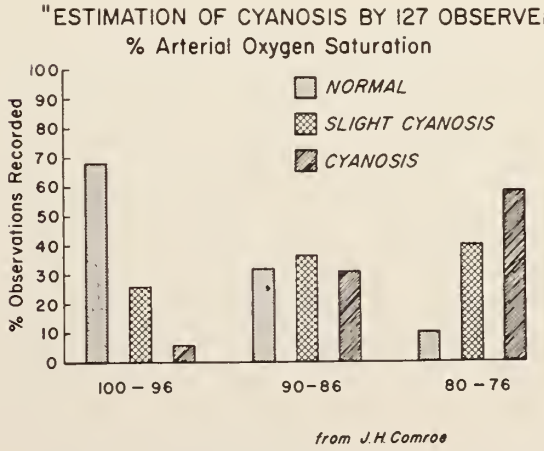


Fig. 5. A comparison of the actual per cent of arterial oxygen saturation to the clinical observation of cyanosis.

lieve we can recognize cyanosis when we see it; however, Fig. 5 reveals the inability of physicians and medical students to accurately detect slight or even marked cyanosis under ideal circumstances.[6] Consequently, we routinely and empirically place patients with intestinal obstruction on oxygen therapy. The arterial pCO_2 serves as a reflection of the adequacy of ventilation and helps in evaluating an abnormal pH. In those patients who develop nonresponsive hypotension, one should suspect acidosis, and in the absence of a pH determination, 44.4 mg. of sodium bicarbonate solution in 500 cc. of 5 per cent glucose in distilled water may be administered as a therapeutic trial. The use of Tris buffer is dangerous because of possible respiratory arrest;[7,8,9] and if it is administered, an anesthetist and the equipment for assisted respiration must be at the bedside.

The renal system is monitored primarily in the acute situation by the hourly urine volume. The kidney is a wonderfully sensitive and responsive organ. It serves as an early, if not the earliest, indicator of inadequate blood volume and tissue perfusion, and in the absence of tubular necrosis, urine flow will be established when the patient is in balance. The use of osmotic diuretics, such as mannitol, has become very popular. The administration of mannitol causes an acute plasma volume expansion with dilutional hyponatremia.[10,11] This may further aggravate electrolyte imbalances or contribute to cardiac failure. If diuresis is established, the increased plasma volume will be reduced and additional sodium ions excreted. For these reasons it is wise not to administer mannitol to the oliguric patient until the central venous pressure has risen to a level of approximately 100 mm. H_2O and the depleted electrolytes have been replaced. When these criteria are met, 12.5 Gm. of mannitol is administered as a 25 per cent solution over a three to five minute period. If this is successful in establishing a diuresis, a satisfactory output can be maintained by titration with 2.5 per cent mannitol in saline. If mannitol is unsuccessful, the diagnosis of renal failure must be entertained and the appropriate diagnostic and therapeutic measures instituted.

Summary

A program is presented for physiological monitoring of the patient with intestinal obstruction during resuscitation. This is designed to continually evaluate the responses of the cardiovascular, respiratory, and renal systems to fluid and electrolyte administration and to each other, thereby permitting rapid and complete replacement without the danger of cardiac overload.

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Dysmenorrhea: Treatment With Papaverine–Double Blind Study

by

J. R. White, M. D.

Tuscaloosa, Alabama

Papaverine* is the most important isoquinoline alkaloid of opium. It is slightly analgetic, yet its actions are quite unrelated to those of morphine. The basic action is relaxing the tonus of all smooth muscle without blocking normal contractions. Mach, 1916,[1] claimed papaverine produced a peripheral vasodilator action.

Primary dysmenorrhea affects an estimated five to eight million women annually in the United States[2] with an economic loss stated to be three times that of the common cold.[3] This condition is a complex of symptoms without objective disease findings that may include depression, irritability and nervousness in approximately 63 per cent of recorded cases and premenstrual tension, gastric upset, backache, and headache in 45 per cent of the cases.[3] Pain is present by definition in 100 per cent of the cases. In this study secondary dysmenorrhea is intentionally not included. The possibility that some of our patients could have been suffering from secondary dysmenorrhea, however, cannot be excluded, yet there was no evidence of pathological conditions on physical examination nor in the patients' history.

I shall not attempt, in the scope of this report, to discuss all the etiologies as proposed by authors for hundreds of years beyond the statement that pain may be due to vasoconstriction in the spiral arteriolar system in the myometrium as reported by Langdon Parsons, Professor of Gynecology at the Boston University School of Medicine.[4] It has also been felt that pain of dysmenorrhea is basically due to vasomotor disturbance within the uterus. Also, Greenblatt[5] in 1941, proposed the use of Priscoline® to produce uterine vasodilation and in a clinical study had an approximately 65-70 per cent good overall result, yet side effects were present in a high percentage.

METHODS AND MATERIALS

Fifty patients with primary dysmenorrhea were selected for this study. Forty-two were white and eight were negro. Thirty-six were multiparous and 14 had from one to four children. The age range of these patients was from 12 to 43 years. All patients were given complete physicals including pelvic examination and pap smears and a detailed history of each patient's past history was made a part of the survey.

In addition, information as to other medications which the patients were taking was elicited and noted. Particular emphasis was directed toward determining whether a pa-

*Supplied as PAVABID® by Marion Laboratories, Inc., Kansas City, Mo.

Dr. White is a general practitioner and surgeon.

tient was taking one of the ovulation interruptors. Most authorities propose that primary dysmenorrhea in an anovulatory patient is of psychic origin. As the number of patients taking this group of medication increased, I noted a definite decrease in the number of patients who had dysmenorrhea. Many others have discussed the lessening of their symptoms, yet approximately 20 per cent still continued to complain of pain.

Realizing that one must be wary of clinical impressions, it must be accepted that any general practitioner or specialist with repeated patient contact will form opinions upon which he can and must rely within the realm of medical judgment. I, therefore, feel that additional studies may throw further light on the etiology of dysmenorrhea as our research capabilities expand.

Twenty-five members of this group were given sustained release capsules of 150 mg. papaverine hydrochloride with a daily dosage of one capsule morning and evening, starting two days prior to the expected onset of menses.

Patients with a history of frequent gross irregularity had been excluded from this study. Even so, it was not infrequent to have a patient miscalculate the starting date by as much as three days. Each patient was advised to take the capsules for a minimum of six doses or until all indications of dysmenorrhea had ceased.

Twenty-five other patients received placebos identical in appearance to the papaverine. Both base drug and placebos were numbered and neither patient nor investigator was aware of the contents of the capsules until after all data were assembled. Each patient took the drug for at least three menstrual periods, although these were not necessarily in sequence.

Each patient was asked to evaluate the effectiveness of the drug toward alleviating pain as: good, fair, or poor, over the three-cycle experiment. Many of these patients are university students living in dormitories or sorority houses. Therefore, we were able to achieve a very high degree of reporting and subsequent follow-up.

TABLE I

RELIEF OF PAIN FROM CRAMPING

PLACEBO RESULTS		
Results	No. of Patients	Percentage
Good	5	20%
Fair	11	44%
Poor	9	36%
TOTAL	25	100%

In our placebo study it was interesting to note the high degree of relief obtained just from the suggestion that "these capsules may relieve your discomfort." Out of 25 patients who received placebos, the results are shown in Table I.

TABLE II

PAPAVERINE RESULTS		
Results	No. of Patients	Percentage
Good	16	64%
Fair	7	28%
Poor	2	8%
TOTAL	25	100%

Later those patients in the papaverine test group who showed poor results were given one capsule q.i.d., a.c. et H.S. and started three days before expected onset of menses, yet the clinical response remained the same. One of these patients has subsequently been placed on an ovulation inhibitor and she still complains of cramping, although to lesser degree. The possibility of endometriosis or other pelvic disease in this patient is under investigation at the present time.

SIDE EFFECTS

With careful questioning monthly and at the end of the three-cycle report periods, I was unable to elicit a single instance that could be construed as an undesirable side effect. One patient stated she had more back

pain and less pelvic area pain, but I feel this is probably a variant of pain distribution.

OTHER EFFECTS

The most constant additional effect noted in the papaverine group and *not* noted in the placebo group was a decrease in the apparent amount of blood flow. In both groups a few patients stated their periods were shorter but only the papaverine group reflected an actual decrease in the amount of flow. Eight of the 25 patients in this group volunteered this information and after the final gathering of data I questioned the remainder of the group and three others noted their amount of discharge was definitely decreased.

Edema was not affected nor was a decrease in premenstrual tension consistent enough to be considered an adequate clinical response.

DISCUSSION

The 64 per cent good results of papaverine hydrochloride in a dose of 150 mg. sustained release capsules twice a day, beginning two days before the onset of menses seems to suggest the possibility of arteriolar spasm being involved in the partial cause of dysmenorrhea. The overall result of good plus fair over placebo results is approximately 25 per cent. No toxic side effects were noted. Eight of the 25 patients on papaverine reported a decrease of menstrual flow. This was entirely the patients' opinion and not verified with measurements of menstrual products.

The fact that 64 per cent of the patients on placebos had fair to good results also tends to confirm that at least a part of dysmenorrhea is psychic in origin.

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4. Hughes; Parker K. J.; of Medical Society, December, 1954.

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Products of Research That Save Lives

Let the law deal harshly with any dishonesty, false claims, or unsafe practices found in the drug industry, but let us not encourage unlimited power by the FDA which could destroy the tree laden with the fruit of honest research because of one ailing branch. We would suggest . . . a resolution of confidence in the pharmaceutical industry whose products have saved the lives of so many children. It is easy to forget that the life of President Lincoln's son could probably have been saved by antibiotics.—Robert F. Lorenzen, M. D., in *Arizona Medicine*, 21: 469, (June) 1964.

More Opportunities to Study Drug Effects

Whatever the methodology used and whoever the physicians who wish to participate in the testing of drugs, all of the groups that are concerned—should be vigilant to see that no one steps beyond his qualifications in testing a drug. And they, together with the Association of American Medical Colleges, should see that the problem of studying drugs in humans is placed squarely before medical students and house officers and that more opportunities are provided for them to observe the effects of drugs on people.—Harry F. Dowling, M. D., in *J. A. M. A.*, 187: 3 (Jan. 18) 1964.

THE FACTS ABOUT . . .

Blue Cross-Blue Shield Of Alabama

By H. F. Singleton

In the June 1964 issue of the Journal of the Medical Association of Alabama Dr. William H. Tucker, of Mobile, a former member of the Board of Directors of Blue Cross-Blue Shield of Alabama had published an article titled "Blue Cross-Blue Shield of Alabama."

While we have no desire to engage in a debate with Dr. Tucker, the Blue Shield Board members of Alabama Blue Cross-Blue Shield have instructed me to clarify statements made by Dr. Tucker.

As for the general tone and content of the Tucker article, we have no idea of its motivation. Dr. Tucker served three years in the fiduciary capacity of Trustee of the Blue Cross-Blue Shield Board, without compensation, as a Blue Shield representative.

However, in order to keep the record straight some 12 statements, in the opinion of the Blue Shield Board members, require clarification or correction.

Number one: "Initially, Blue Shield policies were sold to substandard income groups."

Comment: Initially, *and presently*, Blue Shield contracts are offered and sold to all groups and individuals in Alabama, regardless of income status.

Number two: Table II in the article showed gross billings per day for hospitals for the years 1950 through 1962. The following footnote statement is incorrect: "Deduct 10 to 12 per cent from gross billings to obtain the amount actually received by the hospitals from Blue Cross for care rendered."

Comment: The average billing allowance by hospitals over the period was actually less than 5 per cent, and between 50 to 60 hospitals, varying from year to year, received their full billing under the reimbursement formula.

Number three: "It will suffice to say, however, that the formula is a complicated one. It does not allow anything for bad debts, outpatient care, etc."

Comment: The formula is very simple: Hospitals are reimbursed on a basis of their average billings up to 105 per cent of the average inpatient cost for services covered by the Blue Cross contracts. Outpatient care is not covered by the service agreement between hospitals and Blue Cross; therefore, the hospitals can collect their full billing for outpatient services. As for bad debts, these are intended to be covered in the 5 per cent plus factor. However, studies have repeatedly shown that bad debts from Blue Cross patients average less than one-half of one per cent of hospital income. Further, Blue Cross contracts cover service in only a semi-private room. Any patient, who selects a private room, pays the hospital an appropriate additional amount.

Number four: A corollary statement of Dr. Tucker says that "It is estimated that Blue Cross patients pay 10 to 12 per cent less than those having no insurance or those covered by non-Blue Cross insurance."

*This article was prepared for and reviewed by the six members of the Blue Shield Committee and has this Committee's unanimous approval. H. F. Singleton is President of Blue Cross-Blue Shield of Alabama.

Comment: This statement cannot be substantiated, and is, apparently, a conclusion reached by Dr. Tucker. As was pointed out above, the hospital billing allowance is less than 5 per cent,—not 10 to 12 per cent. A study done in 1957 of five Alabama hospitals also refutes the implication that Blue Cross patients return fewer dollars to the hospital. This study was done from the actual ledger sheets of these hospitals. It showed that the average income from Blue Cross patients per case was $187.84 as compared with the average for non-Blue Cross patients of $179.20 per case. But this is not the whole story. Bad debts from Blue Cross patients were 1.3 per cent; from non-Blue Cross patients, 3.6 per cent. Further analysis showed that billing allowances (discounts) for the Blue Cross patient in these five hospitals was 5.8 per cent; for the non-Blue Cross patient, 6.9 per cent. If we add the Blue Cross bad debts and billing allowances we get 7.1 per cent (5.8 plus 1.3=7.1 per cent); if we add the same figures for non-Blue Cross patients, we get 10.5 per cent (6.9 plus 3.6=10.5 per cent). The facts speak for themselves.

Number five: "All licensed hospitals are approved for membership."

Comment: This is only partly true. All licensed *general hospitals* (not sanatoria, T. B. hospitals, etc.) are eligible for membership.

Number six: "A hospital, if approved by these bodies (Hospital Association Trustees and Board of Censors), must be accepted by Alabama Blue Cross."

Comment: This, again, is only partly true. For *cause,* the Board of Directors of Alabama Blue Cross-Blue Shield, may discontinue the membership of a hospital.

Number seven: "The reimbursement for a day of care for a Blue Cross covered patient is determined by an instructed audit which allows or disallows certain expenses of the hospital based on precedent and special factors too complicated to elaborate on in the scope of this article."

Comment: An independent audit firm does a cost study, not an audit, annually on all member hospitals. Their criteria for finding cost is limited to *services covered* by the Blue Cross contracts only. In finding cost, the principles recommended by the American Hospital Association are used. All, or any part of hospital cost that contributes to inpatient hospital care is included. Excessive interest or rent which goes beyond actual historical depreciation is subject to limitations prescribed by the full Blue Cross-Blue Shield Board of Directors.

Number eight: "The hospitals receive only 'cost' for services rendered Blue Cross patients."

Comment: As has already been pointed out, hospitals receive their billings up to 105 per cent above their costs for inpatient covered services, plus any additional amount for such non-covered services as private rooms, long distance telephone calls, cots and T. V.

Number nine: "It has been estimated this 'cost' is approximately seven to ten per cent less nation-wide of what the hospital would receive if the patient had no insurance or had another type of insurance."

Comment: Again this statement is not substantiated. No reference source for such an "estimate" is given. The statement is not correct, because more hospitals are paid on a billing basis, than on a cost plus basis.

Number ten: ", no allowance for outpatient services and no allowance for obsolescence of equipment,"

Comment: This is an incorrect portion of a statement which purports to show that Blue Cross patients cause deficits which must be "made up" by other patients. First, the allowance for outpatient expenses is not applicable to the service coverage for inpatients. The hospital is free to collect its full bill for outpatient and emergency care rendered Blue Cross patients. Secondly, depreciation of equipment is an allowable expense. An obsolete piece of equipment still in use is depreciated according to its full, original cost; any new equipment is likewise set up and depreciated as an allowable cost.

Number eleven: "If the growth of Blue Cross continues, private insurance will cease to be competitive due to the increased premiums brought about by increased charges to non-Blue Cross patients."

Comment: While Blue Cross continues to show steady, healthy growth, it is a fact that less than one-third of the American people have Blue Cross. Of the 140,000,000 Americans with some sort of hospital insurance, only 59,000,000 have Blue Cross.

Number twelve: "Great pressure by large blocks of subscribers (Labor Unions). These acting in concert with the established policy of the national Blue Shield organization may be too great for management to resist."

Comment: Here, Dr. Tucker is referring to the demands of Labor Unions for full service Blue Shield coverage, and to the policy of the National Association of Blue Shield Plans of fostering service benefits where the local or state medical societies concur. It is important that the medical profession know that there is a desire on the part of *both* labor and management for negotiated service benefits. Such national concerns as the major steel companies and the entire auto industry are working jointly in committees in an effort to obtain full service benefits for their worker-employees. It may be generally stated that both company and union wish to purchase identifiable medical benefits for an agreed-upon price; and further, both desire to explore together with the medical profession the possibility of service benefits.

The Medical Association of the State of Alabama has six (6) physicians on the Board of Trustees, who also serve on the Board of Directors of Blue Cross-Blue Shield of Alabama.

The Blue Cross Emblem belongs to the American Hospital Association which sets the standards with respect to scope of coverage and reserve requirements.

The Blue Shield Emblem belongs to the National Association of Blue Shield Plans, and it sets the standards of benefits and reserve requirements. One of the standards is that the duly constituted local medical society shall sponsor the Plan.

While the majority of Blue Shield Plans are "Service" Plans, the right to offer full service medical benefits rests with the local sponsoring agency—the medical society or association.

In Alabama, the Board of Directors and the Executive Officers are on record with regard to a full service plan for Alabama, either at the county or state level. A service plan will not be offered in Alabama until the Medical Association of the State of Alabama or any constituent county society requests that a full service plan be offered to the public. It would be both impractical and foolish for a Blue Shield Plan to offer any full service plan without the active advice, consent and continuing cooperation of organized medicine. Finally, in Dr. Tucker's article, he states: "It (the Alabama Plan) is even more unique in that it is one of four plans out of 70 U. S. Plans that has a combined Blue Cross-Blue Shield Board." Our understanding of the meaning of the word "unique" is that it cannot be compared or qualified. The facts are that there are actually nine plans (not four) which have combined Blue Cross-Blue Shield Boards. They are Alabama, Arkansas, Delaware, Maine, Mississippi, Chapel Hill, Durham, Chattanooga and Memphis. Of the nine, five offer full service contracts. There are 29 Blue Cross-Blue Shield Plans formed as separate corporations but with the same director, staff and location; there are 13 plans formed as separate c o r p o r a t i o n s, having separate boards, directors and staff, but the same location; and there are 20 plans having separate boards, directors, staffs and locations from any Blue Cross Plan.

With co-operation, guidance, leadership and constructive criticism, of the Medical Association of the State of Alabama, the Alabama Blue Shield Plan can offer the kind of voluntary prepayment plan that will provide a sound basis for financing the medical care of the citizens of Alabama who wish, voluntarily, to enroll.



Editorials

AMERICAN PUBLIC HEALTH ASSOCIATION

The leadership needed to solve such growing community problems as air pollution, water pollution, and traffic safety can be found at the local level among the health teams employed in private industry and trained in preventive medicine.

This was the opinion expressed today by Dr. Henry F. Howe, director, department of occupational health, American Medical Association, in a speech prepared for delivery at the annual meeting of the American Public Health Association.

"The skills of industrial physicians are the best presently available resource to supplement shortages in manpower in many of the public health activities of government," he said.

Machines and chemicals emerging from industry into public use are creating "technological jungles," Dr. Howe warned, and the American people are clamoring for control measures.

"Someone is going to control them," he said.

"Shall they be controlled by fiat from a central bureaucracy, or by the guidance of the local citizenry, depending on talented advisors on the local scene? The Public Health Service shies away from disciplinary functions, hoping that states and cities will accept their responsibilities to control their own problems. Matching Federal grants are available, a compromise to afford local control with Federal assistance. Will the states pick up the gauntlet, and solve their own problems, or will the next phase be Federal control?"

Physicians in industry, along with the other members of the industrial health team, have achieved a dramatic reduction in industrial accident rates and in the incidence of occupational diseases during the past 30 years, Dr. Howe pointed out.

"It is now the total environment which needs a survey of its health hazards," he said.

"Off-the-job safety is becoming a more severe challenge to our society than on-the-job safety. Automobiles kill more people than production machinery.

"Candid surveys of hazards in his own community by an observant industrial physician may be all that is needed to inaugurate a local safety council, a campaign to clean up water pollution, or a project for automotive safety."

Home safety, safety in sports, in agriculture, in scuba diving, parachute jumping, and private aviation need the same sort of analysis in the community that industrial physicians have applied to similar problems in the factory, he pointed out.

The manpower pool represented by physicians practicing private preventive medicine in industry is as large or larger than the pool of similarly oriented public health physicians employed at all levels of government, Dr. Howe estimated.

The industrial health team includes from 3,000 to 5,000 physicians as well as 17,200 industrial nurses and about 1,300 industrial hygienists, he said, while at all levels of government, there are only about 2,000 physicians employed full-time in official public health work.

MIAMI BEACH HOST TO CLINICAL CONVENTION

A scientific program attuned to the current needs and interests of the practicing physician is planned for the 18th clinical convention of the American Medical Association.

Immunization, depression, cardiac arrhythmias, vascular occlusive diseases, emphysema, iatrogenic diseases, and hypertension are only a few of the major areas to be explored during the four-day meeting, Nov. 29-Dec. 2.

More than 300 physicians will participate in a full program of lectures, exhibits, motion pictures, color television, fireside conferences and breakfast roundtables.

A new feature of the clinical convention this year is a postgraduate course on obstetrics for the general practitioner. Fifteen lectures will be presented during three sessions ranging from infertility and prenatal care through complications of labor and anethesia to postnatal care and maternal mortality. Chairman of the course is Ralph W. Jack, M. D., Miami.

The entire scientific program, with the exception of the fireside conferences and breakfast roundtables, will be held in Miami Beach Convention Hall. The modern, single-level structure, completed in 1959, is fully air-conditioned and boasts one of the finest sound amplification systems to be found anywhere in the nation. It is located just one block from the Lincoln Road shopping centers, Florida's Gold Coast and the ocean.

The popular fireside conferences, presented as a joint session of the American College of Chest Physicians and the AMA, will be held Sunday night, Nov. 29, at the Fontainebleu Hotel. There will be 11 tables at which 50 to 60 discussion leaders will engage in an informal and free exchange of views on a variety of medical subjects.

Six breakfast roundtables are scheduled at the di Lido Hotel. Topics include cancer of the thyroid, cosmetic surgery and peptic ulcer.

In addition, 125 scientific exhibits will be on display during the meeting, including a special exhibit on fractures, and some 30 medical motion pictures will be shown in the afternoon Monday through Wednesday.

General chairmen of the local committee on arrangements are Clifford C. Snyder, M. D., and Nelson Zivitz, M. D.

Three prominent men of medicine will deliver mid-day lectures during the AMA Clinical Convention.

Edward R. Annis, M. D., Miami, immediate past president of the AMA, will speak on "The Physician as a Diplomat" on Monday, Nov. 30.

Geza de Takats, M. D., Chicago, an eminent vascular surgeon, will discuss "Diabetic Vascular Disease" on the following day. Dr. de Takats, born in Budapest, Hungary, had a long and distinguished career as clinical professor of surgery at the University of Illinois School of Medicine.

The third lecture, "Medical Aspects of Space Flight," will be presented Wednesday by Col. Andres Ingver Karstens, M. D., an authority on space medicine, now serving with the Air Force Space Systems Division, Los Angeles. Col. Karstens was commanding officer of the Arctic Aeromedical Laboratory, Ladd Air Force Base in Alaska from 1950 to 1955, served as director of research, aviation medicine, Randolph Air Force Base, Texas, from 1956 to 1958, and later served at Wright-Patterson Air Force Base, Dayton, Ohio, and Brooks Air Force Base, San Antonio, Texas.

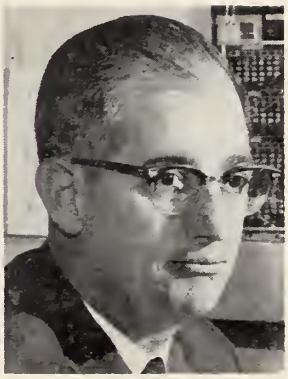
Another highlight of the scientific program will be a series of eight lectures on vascular occlusive diseases on the final day of the meeting. Phlebitis, pulmonary embolism, carotid atherosclerosis, and peripheral arte-

rial disease will be reviewed by J. Alex Haller, Jr., M. D., associate professor of surgery, The Johns Hopkins Hospital, Baltimore; David C. Sabiston, Jr., M. D., also of the Johns Hopkins; Robert R. Linton, M. D., Brookline, Mass.; Richard T. Shackelford, M. D., Baltimore; E. Stanley Crawford, M. D., Baylor University College of Medicine, Texas Medical Center, Houston; Alexander Blain, III, M. D., Detroit; John L. Ochsner, M. D., New Orleans; and W. Sterling Edwards, M. D., Medical College of Alabama, Birmingham.

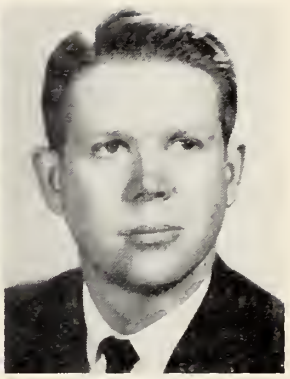
Emphysema, fast becoming a leading cause of death and disability in older men, will be discussed in two lectures followed by a symposium. Participants will be Herbert C. Sweet, M. D., St. Louis University School of Medicine, St. Louis; Harold A. Lyons, M. D., professor of medicine, University of State of New York, Downstate Medical Center, Brooklyn, N. Y.; and Asher Marks, M. D., associate professor of medicine, University of Miami School of Medicine, Miami.

Similar sessions will be held on cardiac arrhythmias with Edward S. Orgain, M. D., professor of medicine, Duke University Medical Center, Durham, N. C.; Stuart W. Rosner, M. D., U. S. Public Health Service, Washington, D. C., and Louis Lemberg, M. D., University of Miami School of Medicine, Miami, participating; and on hypertension with William H. Hulet, M. D., associate professor of medicine and physiology, University of Miami School of Medicine, Coral Gables; John H. Moyer, M. D., professor, department of medicine, Hahnemann Medical College and Hospital, Philadelphia, and Hugh R. Gilmore III, M. D., associate professor of medicine, University of Miami School of Medicine, Miami, as participants.

Other sessions will be devoted to immunization; venereal disease; aviation medicine; peptic ulcer, pancreatitis, and abdominal pain; depressive states; breast cancer; gastrointestinal diseases; autoimmunity; pyelonephritis; radioisotopes in diagnosis; rehabilitation; and iatrogenic diseases.



PATTERSON



CRAWFORD

L. P. PATTERSON NAMED MASA ASST. SECRETARY

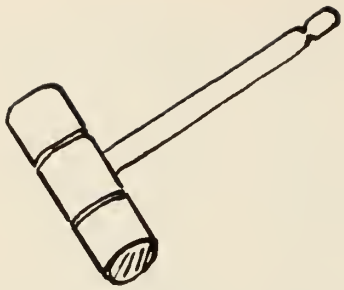
Changes in executive personnel of the Medical Association of the State of Alabama have been announced by William V. Wallace, executive secretary.

Named to the position of assistant executive secretary and managing editor of both the Journal and The Alabama M. D. was L. P. Patterson, former managing editor of the Montgomery Advertiser. Mr. Patterson also will serve as staff assistant to the Committee on Legislation, Committee on Aging and the Indigent, and the Committee on Insurance.

In the post of assistant executive secretary, Mr. Patterson succeeds Marshall R. Crawford, who resigned October 1 to accept the position of executive secretary of the Jefferson County Medical Society. Mr. Crawford had served MASA as executive assistant since February 1, 1961.

Mr. Patterson was born at Andalusia, Alabama and was reared in Georgia where he attended North Georgia College at Dahlonega. He was employed for a number of years by the Atlanta (Ga.) Journal and was managing editor of the Columbus (Ga.) Ledger, and the Dothan (Ala.) Eagle before joining the Advertiser staff in 1957.

His previous experience with the medical profession includes two years as director of public relations for the Fulton-DeKalb Hospital Authority, which operates Grady Memorial Hospital in Atlanta.



President's Page



The final days of the 88th Congress saw the end of the attempt this time to pass the so-called Medicare Amendment in Congress. There had been rumors and newspaper statements that Mr. Johnson, the President, felt that a landslide victory gave him a mandate to call a special session of Congress to complete his legislative program. There has been no question that the 88th Congress passed more legislation than any other in "modern times". The **Aid-to-Appalachia** program failed to get approval by the Congress but it is reliably stated that Mr. Johnson has found the money from other sources to support this program. Medicare died but no one doubts it will be revived again.

On the other hand, there is no question that the Conservative movement has gained ground recently. Whether a vindictive attitude toward the Southern States that do not go along will split this nation is difficult to say. But the right to have a difference of opinion is part of our basic heritage. To be punished for it is tragic.

Medicine can no longer be pushed around. It is not hard to understand from where the philosophy of the Welfare State in America arises when one listens to Seymour Harris, Ph. D., Professor Emeritus, Harvard University. This man was Economic Advisor to the late John F. Kennedy when he was a Senator. At a recent Blue Shield Meeting in Chicago Dr. Harris talked on the subject "An Economist Looks at Blue Shield." In Blue Shield there are 25 Service Plans against 14 Indemnity Plans. From the stand point of the

administrator the Service Plan is the simplest to operate. Also, the public wants the Service Plan or a "plan that pays all the bills". One-Seventh of Americans are covered by Blue Shield, Dr. Harris states. More resources have been brought into medicine by voluntary health plans and thus, National Health Insurance has not been able to progress. He stated it will be a miracle, if the aged and those in the labor market are not completely covered by 1970. A National Health Plan is bound to gain, in Dr. Harris's opinion. Hospitals have no endowments for the low income groups so state and local governments must foot the bill. Kerr-Mills costs $200 million a year. It works in Texas and a few other states but some states only give three days per year to the beneficiaries. $2 billion is required to make Kerr-Mills operate adequately. Blue Cross-Blue Shield is unable to do the job in the way the people demand it, Dr. Harris stated.

The reasons for this failure are rising hospital costs, competition of private insurance companies that go in for the indemnity plans, major medical supplements of private insurance companies up to $10,000, and the inadequacy of the coverage up to $6000 of income. A $10,000 limit would cover 85 per cent of the population. If an automatic increase of 5 per cent a year were instituted in premiums and coverage the rise in costs and income levels would balance out, Dr. Harris thinks. Increase in coverage has not kept pace with the rise in income and costs.

Then he hit the doctors. "Doctors want to be free to deal with patients on the basis of what the traffic will bear. Medical Societies and Blue Shield cannot get together." Dr. Harris said, "The Doctor's income is high. There has been a 500 per cent increase in doctor's income since 1930. (Ed. Note. This was the beginning of the depression of the '30's.) There has been a gain in the collection of bills and an increase in the price of service," he stated. "No real increase was noted in the fees of physicians before 1930 but there has been a steady increase since then," Dr. Harris said. (Ed. Note. With this we do not agree completely, collections have been better.) He said the doctor is a "victim of the free market system." "The larger his practice the more money he collects, so he reduces the volume by charging more and cutting his time in the office. As a consequence fewer p e o p l e get attention. Dr. Harris's solution is to train more doctors by increasing the size and number of Medical Schools with a Government subsidy. In 40 years he predicted a doctor's lifetime income will be two million dollars. In 20 years there will be 20 per cent more specialists and 20 per cent less g e n e r a l practitioners. The specialties being sought by the young doctors will be the ones with the highest income. The conclusion, according to Dr. Harris, is that the doctors are motivated by economics.

In summary then, Dr. Harris felt because the doctor's income is high and they are victims of market forces that more doctors are needed. And since costs are going up 5 per cent automatically a year increase in premiums and coverage are necessary to keep pace with a rising economy. As far as the area situation is concerned the low income groups go in for major medical. "It is not as effective as it is thought to be." "The King-Anderson Bill originated to provide more complete coverage."

Dr. Harris did have a sense of humor. In defining the oldest profession in the world, it was in the field of economics since it was the economist "who brought on all the chaos."

E. B. Glenn, M. D.



ASSOCIATION FORUM

SURVEY SEEKS TO DEFINE MENTAL HEALTH PROBLEMS

By William H. Tragle, M. D.

Director, Division of Mental Health Planning
State of Alabama Department of Public Health

A survey currently underway in Alabama is aimed at defining the mental health problems of every county in the state by June, 1965. In addition to identifying the nature and prevalence of mental problems in each area, studies are intended to show resources and facilities and to determine local readiness to support additional programs.

Studies of the state's mental health situation have been made before, but a Grant-in-Aid program in which the Department of Public Health is now participating will bring to light for the first time, the special needs of individual areas. Techniques in use include interviewing random household samples by volunteer workers. Completion of the survey will make possible ranking of the counties according to relative need, so that the most advantageous use of federal construction funds may be made, when they become available.

To be administered over a three-year period, the first of this money will be ready next summer. Expectations are that Alabama's share of a $150 million appropriation, authorized by the Community Mental Health Centers Act, will be $3,425,000. Every two dollars of federal money must be matched with one dollar of state or local funds. Specific problems, in addition to raising matching funds, will be obtaining other money for operation, as well as recruiting and retaining trained personnel.

Preparation of "A Comprehensive Community Based Mental Health Plan For Planning For the State of Alabama" was initiated by the Division of Mental Hygiene and gained momentum last December with the organization of the Division of Mental Health Planning. Involved in the plan is a contract with the University of Alabama Department of Sociology and Anthropology to devise standard survey methods by conducting six pilot studies.

Subsequently, steering committees of civic leaders were formed in the Muscle Shoals area, and in Madison, Jefferson, Shelby, Barbour and Mobile Counties. The University then conducted interviewers' institutes, refining procedures as experience was gained.

Reprinted from October, 1964 "Alabama Social Worker."

The first household survey was conducted in Jefferson County in June, and before the others were undertaken, the original questionnaire was expanded and improved.

Terms of the contract with the University are for completion of the pilot studies by the end of December, when participating communities will have received analyses of the findings by the sociology department. Processing of the data is by IBM, with complete anonymity assured household respondents.

By mid-winter, surveying of the remaining sixty counties will be accelerated. Based on population requirements that the mental health centers serve no less than 75,000 nor more than 200,000, indications are that from twenty-five to thirty will be developed in Alabama. In some instances, several counties will have to pool their resources, in order to meet the population stipulation, but all areas will be served.

According to the plan, it is possible that already existing facilities and services in certain communities will be supplemented by others in order to round out the range of care deemed necessary. Five elements are required: out-patient service, in-patient service, partial hospitalization, emergency care and consultation and education. Prevention and rehabilitation will be important aspects of the programs, along with treatment.

While the various services may be administered and housed under separate auspices, it is important that a patient receive continuity of care and be treated as an individual. The net effect will be that he has needed services available to him at the time he needs it, unimpeded by red tape.

The centers will be in accord with recommendations of the Joint Commission on Mental Illness and Health that patients be cared for in a familiar environment. In many instances, individuals may continue to work and carry on relatively normal lives, averting the necessity for long-term confinement in a state institution.

Of the various problems involved in seeing the centers become a reality, one of the knottiest will be meeting a stipulation for adequate staffing. Currently, the University of Alabama Medical Center's Department of Psychiatry turns out three or four psychiatrists a year, but plans are underway for doubling the number.

The center is approved for two years of advanced training for child psychiatry, in addition to the three-year program for general psychiatry. Plans have been completed for construction of a one-hundred bed psychiatric hospital at the center, and expansion is underway at Smolian Psychiatric Clinic.

The Birmingham Veterans' Administration Hospital has participated in the training of psychiatrists since 1956, and the Tuscaloosa Veterans' Administration hospital now has plans to take part.

The University of Alabama's psychology department conferred two Ph. D. degrees during 1963-64. There were no master's degrees awarded, but nineteen bachelors degrees were earned. At Auburn, a Ph. D. program in psychology is being contemplated for the near future. During the past year, four master's degrees and fifteen bachelor's degrees were earned by Auburn psychology students.

Students of nursing have been undergoing the three-months phase of their psychiatric training at Bryce since about 1960; and an extensive program for aides and attendants is continuously growing. Steps are being taken for a graduate school of social work at the University of Alabama. In coming months, an educational television series in mental health will be directed at the professional nurses' level as an in-service training program.

Every community visited by the planning staff has shown great interest in our operation. Citizens with whom we have talked are looking for help in meeting their local problems. We have seen many instances of ingenuity and resourcefulness in communities without specialized facilities, and those may be the first to recognize how great are the needs. Regardless of the nature and quality of our planning, it will be these people who will make its realization possible.

AMA POSITIONS ON LEGISLATION ENACTED IN 88TH CONGRESS

During the 88th Congress, the American Medical Association presented testimony on twenty-two legislative proposals. Of these, twelve became law. The following is a brief comparison of the provisions of the laws which were enacted and the Association's recommendations with respect to each.

Hill-Burton Amendments—P. L. 88-443 (H. R. 10041)

Law

This law, which completely rewrote the Hill-Burton Act, authorizes a five-year, $1.34 billion program of matching grants for the construction and modernization of hospitals, public health centers, long-term care facilities, diagnostic or treatment centers, and rehabilitation centers. Grants can range between one-third and three-fourths of the cost of construction. States are authorized to transfer portions of funds for construction to modernization under a formula contained in the law. As under the original Hill-Burton program, before grants can be made for a project in a state, the state must submit a state plan.

The law also authorizes the annual appropriation of $10 million to be used to conduct research and to make grants to the states and other nonprofit organizations for studies and demonstrations on the use of hospital facilities.

The law also authorizes the appropriation of $22.5 million over a five-year period to be used to make matching grants (50-50) for the cost of projects to develop and to supervise the carrying out of comprehensive regional, metropolitan, or local area plans for the coordination of existing and planned health facilities and services.

AMA Position

The Association supported the construction provisions in the House and Senate with the recommendation that the categorical grants be eliminated.

It recommended the deletion of a provision in the original bill to establish a mortgage insurance program operated by the Surgeon General, and urged that the program be operated, as under existing law, by the Federal Housing Administration.

The Association recommended that a larger percentage of funds for modernization be made available for use at an earlier date than was provided in the bill; that at least two physicians be included in the membership of the Federal Hospital Council; that diagnostic and treatment centers be deleted as facilities eligible to participate in the program; that public health centers be limited to those facilities which are operated by an official public health department; that area-wide planning for hospitals and related facilities remain on a voluntary basis; and that Congress restate its intention that the non-governmental character of a hospital would not be affected by its participation in the Hill-Burton program.

The Congress accepted the Association's recommendations with respect to continuing the mortgage insurance program under the Federal Housing Administration and to the operation of public health centers by official public health departments.

Nursing Home Care for Veterans—P. L. 88-450 (H. R. 8009)

Law

This law authorizes the establishment of at least 4,000 beds for furnishing nursing home care at VA facilities. It also authorizes the transfer of veterans to public or private nursing homes which meet standards established by the Veterans' Administrator. It increases from $2.50 to $3.50 a day the federal grant to state veterans' homes when a veteran who is eligible for VA hospital care is provided nursing home care. It authorizes a five-year, $25 million program of matching grants to states for the construction of state veterans' home facilities for furnishing nursing home care to war veterans.

AMA Position

The AMA submitted statements to both the House and the Senate. Testimony was limited to the provision establishing the grant program for the construction of nursing home care facilities at state veterans' homes. In the House, the Association expressed its opposition to this provision on the basis that veterans with non-service-connected disabilities would be treated in such facilities. In the Senate, the Association expressed the belief that a federal grant program was unnecessary in that the bill provided for the construction of nursing home care beds in VA facilities, and for the transfer of veterans who needed further care to public or private nursing homes. The Association pointed out that the anticipated growth of public and private nursing homes under the impetus of the Hill-Burton and Federal Housing Administration mortgage insurance programs would also make such a program unnecessary.

The Association's recommendations were not accepted.

* * * * * *

Doctor Draft—P. L. 88-2 (H. R. 2438)

Law

This law extends for four years, until July 1, 1967: (1) the doctor draft; (2) the special pay for physicians and dentists; (3) the regular draft act; (4) the Dependents Assistance Act under which allotments are paid; and (5) the law which suspends the limitation on the size of each of the armed forces.

AMA Position

The AMA testified before the House only, making the following recommendations: (1) if necessary for the defense and security of our nation, in the opinion of the Congress, this legislation would be "one method to insure sufficient physicians for military service"; (2) that other specialists, such as engineers, physicists, and scientists, be subject to the special draft; (3) that rather than a four-year extension, a "lesser period" would be sufficient (the AMA witness, in response to a question, expressed the belief that two years would be sufficient); and (4) that a review be made of military manpower requirements in light of changes in the military situation and the needs of the civilian population.

Mental Retardation Facilities and Community Mental Health Centers Construction Program—P. L. 88-164 (S. 1576)

Law

This law establishes a four-year, $26 million matching grant program for the construction of research facilities in the field of mental retardation. A grant under the program could be up to 75% of the cost of construction.

It also authorizes a four-year, $32.5 million program of direct grants for the construction of university-affiliated clinical facilities to provide services for the mentally retarded and for the training of physicians and other specialized personnel to work in this field. Grants could be up to 75% of the cost of construction.

The law establishes a four-year, $67.5 million program of matching grants to the states for the construction of public or nonprofit facilities for the mentally retarded. The federal share of the cost of construction ranges between one-third and two-thirds.

The law also authorizes a three-year, $150 million program of matching grants to the states for the construction of community mental health centers. Grants range from one-third to two-thirds of the cost of a given project.

AMA Position

The AMA testified in the Senate on S. 755 and S. 756 and in the House on H. R. 3688 and H. R. 3689. S. 755 and S. 756 evolved into S. 1576, which became law.

The AMA supported grants for the construction of the various facilities.

It recommended that the programs be administered by the state health agency; that the advisory council under both programs contain medical representation; and that a provision authorizing grants for the cost of initial staffing of community mental health centers be deleted.

The committee left to the states authority to determine what agency would operate the program and provided that the Federal Hospital Council would be the advisory council. The initial staffing provisions were deleted.

* * * * * *

Medical Care for Fishing Boat Owners—P. L. 88-424 (S. 978)

Law

This law authorizes free hospital, medical, surgical, and dental care at PHS hospitals for the owners of fishing boats which are registered, enrolled, or licensed under the federal maritime laws, provided the individual performs services comparable to those of a seaman employed on a vessel.

AMA Position

The AMA filed statements in opposition to this legislation in the House and the Senate. After citing the Hoover Commission report which opposed medical care for seamen, the Association pointed out that there is no justification for extending free care to individuals who can and should provide for their own medical and dental care from their own resources or through the purchase of private health insurance. The Association further pointed out that the provision of such care to the self-employed is not justified either by need or by any special relationship with the federal government.

Nurse Training Act—P. L. 88-581 (H. R. 11241)

Law

This law authorizes a four-year, $35 million matching grant program for the construction, replacement, or rehabilitation of collegiate schools of nursing; and a four-year, $55 million matching grant program for the construction, replacement, or rehabilitation of associate degree or diploma schools of nursing. Grants for a new school or for new facilities at an existing school could be up to two-thirds of the cost of construction. All other grants cannot exceed 50%.

The law also authorizes a nine-year grant program to collegiate or associate degree schools of nursing to assist them in meeting the additional costs of programs of limited duration which will strengthen, improve, or expand their programs of teaching and training nurses.

The law also authorizes the appropriation of $41 million over a five-year period as grants to diploma schools of nursing to defray a portion of the cost of students whose enrollment can reasonably be attributed to the enactment of the law. Diploma schools can receive an amount equal to $250 times the number of "federally sponsored" students in the school during the year, up to a maximum of $100 times the total number of students in the school that year. A "federally sponsored student" is defined as one who has received a loan of more than $100.

The law establishes a loan program patterned after the National Defense Educational program. A student nurse could receive a loan of up to $1,000 bearing 3% interest during any academic year. Up to half the loan could be cancelled, at the rate of 10% a year, for five years of full-time employment as a professional nurse.

Finally, the law authorizes the appropriation of $50 million over a five-year period to cover the cost of traineeships for the training of professional nurses to become teachers or administrators or other specialists determined by the Surgeon General to require advanced training.

AMA Position

In letters to both the House and the Senate, Dr. Blasingame pointed out that the AMA: (1) supported the construction provisions; (2) had no position with respect to the provisions relating to traineeships for advanced training of professional nurses; and (3) opposed the scholarship and loan provisions as an unwise extension of federal subsidization of undergraduate education. Dr. Blasingame expressed the Association's belief that nursing would not be made more attractive by a loan program, and that a more effective approach would include an educational program, improved compensation, utilization of married retired nurses, and other mechanisms.

The committees deleted a provision relating to the establishment of a scholarship program, but retained the loan program.

Clean Air Act—P. L. 88-206 (H. R. 6518)

Law

This law completely rewrote the air pollution control law and made it permanent. Under its provisions, the Secretary of HEW is required to encourage cooperative activities by state and local governments for the prevention and control of air pollution, the enactment of improved, uniform laws on the subject, and the making of agreements and compacts between the states for this purpose.

He is also required to establish a national research and development program for the prevention and control of air pollution. The law authorizes appropriations totaling $95 million. Up to 20% of annual appropriations may be used to make grants to air pollution control agencies for up to two-thirds of the cost of developing, establishing, or improving air pollution prevention and control.

The law considerably increases federal responsibility in enforcing air pollution control. If action to abate or control air pollution is not taken after a conference and a public hearing, the Secretary is authorized, in the case of **interstate** pollution, to request the Attorney General to bring suit on behalf of the U. S. to secure abatement. If the pollution is **intrastate,** at the request of a governor, the Secretary is required to provide the state with technical and other assistance for use in a judicial proceeding under local law or to request the Attorney General to bring suit on behalf of the U. S.

The law also requires the Secretary to encourage continued efforts on the part of the automotive and fuel industries to develop devices and fuels to prevent pollutants from being discharged from automotive vehicles.

AMA Position

In a letter to the Chairman of the Special Subcommittee on Air and Water Pollution of the Senate Public Works Committee, Dr. Blasingame pointed out the Association's belief that the control of air pollution can best be accomplished by continued cooperative and coordinated efforts of government, industry, and local communities. He indicated the belief that the federal government's role in the problem can best be done by federal grants for the development of research activities and the encouragement of state and local programs for the prevention and control of air pollution. He stated, however, that there appears to be no need to empower a federal agency to seek from the courts a remedy which is already available to individuals and to state or local governments.

The Association's recommendation on enforcement was not accepted.

* * * * * *

Loans to Students of Optometry—P. L. 88- (S. 2180)

Law

This law would make students in schools of optometry eligible for loans under the provisions of the Health Professions Educational Assistance Act.

AMA Position

In a letter to the House committee, Dr. Blasingame recalled to the committee the Association's objections in the past to a student loan program for medical and other students, and urged rejection of the bill.

Revenue Act of 1963—P. L. 88-272 (H. R. 8363)

Law

Among other things, this law eliminates the limitation of deductibility of sums spent by a taxpayer aged 65 or over for medicines and drugs which are in excess of 1% of his adjusted gross income.

AMA Position

In commenting on the President's tax proposals, the Association took the following positions: (1) endorsed the elimination of the 1% floor on drug expenses for aged individuals; (2) supported the President's recommendation that the maximum dollar limit on medical deductions be eliminated; (3) opposed the President's recommendation that deductions, including medical deductions, be allowed only to the extent that they exceed 5% of adjusted gross income; (4) opposed a recommendation which would have limited deductions for facilities, services, and devices which are primarily for medical purposes; and (5) opposed any limitation on the deductibility of transportation costs incurred in obtaining specialized medical services outside the local area.

The Association made three specific recommendations: (1) that a tax credit be granted under which the amount of the individual's income and his medical expenses would be related, thereby providing greater relief to the individual with larger medical expenses in proportion to his income; (2) that taxpayers over age 65 be authorized the use of a five-year carry-forward and a three-year carry-back for medical expenses; and (3) that the taxpayer be granted a deduction in full for amounts paid for any dependent. In this connection, the requirement in existing law that the taxpayer have paid more than one-half of the so-called dependent's support would not apply.

* * * * * *

Military Pay Bill—P. L. 88-132 (H. R. 5555)

Law

This law, in addition to increasing the pay of military personnel, provides for an increase from $200 to $250 per month in the special pay for physicians and dentists who have at least six years of active duty, and from $250 to $350 per month for those with ten years of active duty.

AMA Position

The AMA testified in the Senate only (these provisions were not contained in the House bill) and recommended an increase from $200 to $300 after six years' service, and from $250 to $400 after ten years, in order to equalize the pay of military physicians with that of other physicians in the federal service.

Maternal and Child Health and Mental Retardation Planning Amendments—P. L. 88-156 (H. R. 7544)

Law

This law provides periodic increases in the appropriation authorizations for the Maternal and Child Health and for the Crippled Childrens Programs from $25 million, so that by 1970 the appropriation authorizations would reach the level of $50 million annually.

It also authorizes appropriations of $110 million over a five-year period to be used to help meet the cost of special projects for maternal and infant care. Under this program, the federal government could pay up to 75% of the cost of any project to provide necessary health care to prospective mothers from low-income families who have or are likely to have conditions which could lead to physical or mental defects in the infant.

It authorizes the appropriation of $8 million annually for grants for research in Maternal and Child Health and Crippled Childrens Programs.

AMA Position

In a letter to Chairman Wilbur Mills of the House Ways and Means Committee, the AMA supported H. R. 3386, the predecessor of the bill which became law. In his letter, Dr. Blasingame made specific recommendations for improvements in the bill.

With respect to the mental retardation grants, the AMA recommended that the program be operated by the state health department. This recommendation was not accepted.

He also recommended that medical care for prospective mothers be limited to pre- and post-natal care and that the determination of eligibility be tightened by striking vague language contained in the bill.

The bill was amended by the House Ways and Means Committee by striking the word "all" from the phrase "all necessary care" and by leaving the determination of need for care to the state or local health agency.

* * * * * *

Health Professions Educational Assistance Act—P. L. 88-129 (H. R. 12)

Law

This law establishes a three-year, $175 million matching grant program for the construction, replacement, or rehabilitation of nonprofit facilities for the training of physicians, dentists, pharmacists, optometrists, podiatrists, nurses, or professional public health personnel. Grants for the construction of new facilities could be up to 66-2/3% of the cost. Grants for all other construction could not exceed 50% of the cost with the exception of a grant for a school of public health, which could be up to 75% of the cost.

The law also establishes a loan program for students in schools of medicine, dentistry, and osteopathy. $30.7 million is authorized to be appropriated for the first three fiscal years, and such sums as are necessary for the following three fiscal years, to allow a student who received a loan for an academic year before July 1966 to complete his education.

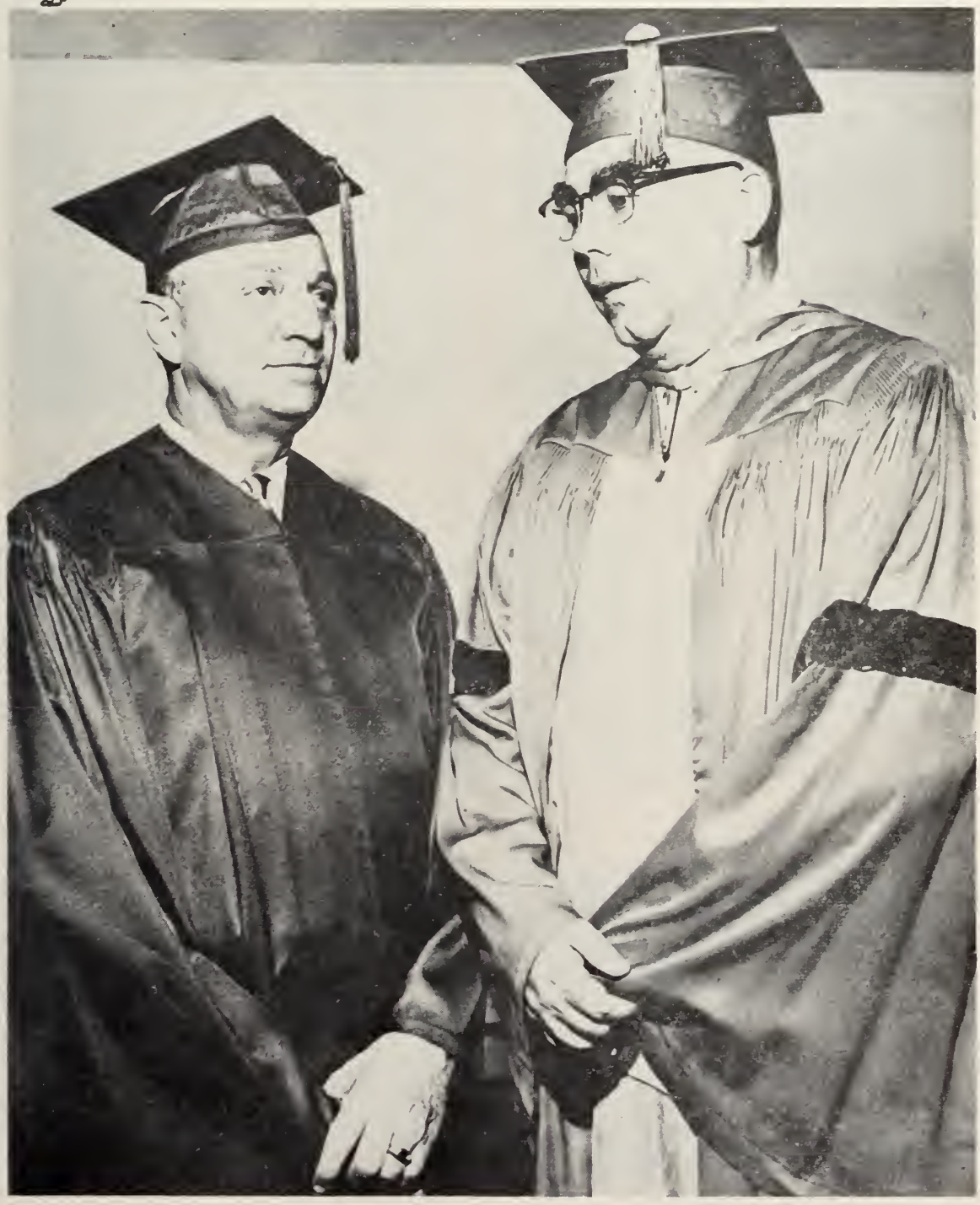
AMA Position

Before House and Senate committees, the Association favored the construction provisions.

With respect to the loan programs, initially the Association took no position; subsequently, the Council, the Board, and the House of Delegates established a position of opposition to the loan provisions.

While not accepting the Association's recommendations with respect to the loan program, the committee did delete a provision which would have authorized cancellation of a portion of the law for service in certain areas specified by the Secretary of HEW.

around the state



Matthew F. McNulty, Jr., (right), General Director, University of Alabama Hospitals and Clinics, is pictured with Luther L. Terry, M. D., Surgeon-General of the United States at the annual meeting of the American College of Hospital Administrators where Dr. Terry was named Honorary Fellow of the College.

McNulty, a Fellow in the College and Regent for the State of Alabama, was Dr. Terry's host for the day, and presented the citation in connection with his Honorary Fellowship.

Candid Camera Highlights of Fourth Dixie Postgraduate Assembly





(Above) Dr. W. J. B. Owings (left) and Dr. C. W. Neville enjoy seafood at Dauphin Island session Sept. 25-26. (Below) Dr. L. R. Burroughs and his three children, Len, III, Jennie and John, inspect cannon at Fort Gaines.



(Above) Dr. M. V. McLaughlin and Dr. Floris M. Herbert discuss AMA-ERF exhibit. (Below) Dr. William P. Beetham, Jr., one of the speakers. (Left) The Battleship USS Alabama as seen from Mobile Bay causeway.





(Above) Newly-inaugurated president of the Alabama Academy is Dr. M. Clifford Holcomb, Jr., of Birmingham.



Of Alabama Chapter, American Academy of General Practice . . .





(Above) Dr. Amos Johnson (left), president-elect of the American Academy of General Practice is greeted by Dr. J. Michaelson, president of AAGP. (Below) Dr. James L. Goddard, chief of the Communicable Disease Center, Atlanta and assistant surgeon general, U. S. Public Health Service.



(Above) Dr. and Mrs. Lowell Clemmons on parade ground at Fort Gaines. (Below) A gay group boarding bus for Alabama-Tulane football game included Dr. R. O. Rutland, Mrs. George Newburn, Mrs. Rutland and Mrs. Joyce Fisher, executive secretary of the Academy.





Alabama Department of Public Health

ALABAMA WATER IMPROVEMENT COMMISSION RESPONSIBILITIES, ACTIVITIES AND ACCOMPLISHMENTS

Ira L. Myers, M. D., State Health Officer
Chairman, Water Improvement Commission

STATUS OF POLLUTION CONTROL

a. Municipal Wastes

Progress in the abatement and control of municipal wastes is most impressive. From 1950 through 1963, 179 sewage treatment plants having a capacity of 194.57 million gallons per day were completed at a cost of $33,406,800. From 1950 through 1963, 530 sewer projects involving 1,757 miles of sewers and 242 pumping stations were constructed at a cost of $60,707,646.

In 1942, 734,362 persons were served by community sewer systems but treatment was provided for only 262,872 persons or 35.8 per cent of the sewered population. At the end of 1963 sewer systems accommodated 1,546,658 people of the state. Of this number 1,369,502 persons or 88.5 per cent of the sewered population were served by systems with treatment facilities. Sewage treatment facilities serving only 75,000 persons or 4.8 per cent of the sewered population are considered to be inadequate.

Although progress in the control of pollution by municipal and domestic wastes over the past 14 years has been remarkable, problem areas still exist over the state. A survey of municipal sewage treatment inadequacies as of January 1, 1964, reveals 66 municipalities serving 275,828 persons in this category. Thirty-six of these municipalities are taking steps to improve their situations and at least 11 are expected to complete or begin construction of sewage treatment facilities during 1964. Many of the remaining 30 municipalities represent a hard core of resistance to persuasion and the cooperative or conference approach.

b. Industrial Waste

As would be expected under the present law, some industries exempt from waste regulation are not inclined to spend vast sums of money for treatment facilities until required to do so. Nevertheless, nine industries with consequential waste discharges in 1949 have made some effort to reduce pollution resulting from their discharges. In most instances these efforts have been in-plant changes for recovery purposes although physical treatment facilities have been installed at five plants.

The major problems of industrial pollution in the state are caused by wastes discharged by industries exempt from control by provisions of the water pollution control law. The areas in which these problems occur have been previously defined.

Investigations presently underway on the effects of wastes discharged from private industries operating within the boundary of Redstone Arsenal may reveal the Huntsville Spring Branch and Indian Creek embay-

ments on Wheeler Lake, Tennessee River to be heavily polluted.

There are 74 industries subject to the Commission's control including three which have increased the quantities of pollution over that occurring in 1949. Four of the so-called new industries have developed major problems and are now in the process of correction and five are creating minor situations of a less than consequential nature.

Of the 115 industries not subject to the Commission's authority, 25 are major and 90 are minor waste sources. Seventeen major and 70 minor sources in this group need waste treatment.

All major industrial contributors of waste subject to the authority of the Commission are being required to analyze regularly their wastes and monitor waters receiving these wastes. Monthly reports of waste analyses and analyses of samples collected from the receiving waters are submitted to the Commission.

c. Interstate Pollution

Within the past two years, Alabama has been a party to two conferences on interstate pollution called by the Secretary of Health, Education and Welfare under the provisions of the Federal Water Pollution Control Act. One of these conferences involved interstate pollution of the Conecuh-Escambia River system from sources within Alabama which were alleged to affect the welfare of citizens of Florida. The finding of this conference was that interstate pollution subject to control under the Federal Water Pollution Control Act did not exist.

The other conference was held on interstate pollution of the Coosa and Chattooga Rivers in Georgia which affected the welfare of citizens of Alabama. The finding of this conference was that interstate pollution subject to control under the Federal Water Pollution Control Act did exist and that stipulations for correcting this situation were in order.

d. Other Problems

One of the problems confronting the Commission is apparent lack of public understanding of water pollution, its control and the true situation existing in the state with respect to water quality conditions. In many instances it appears that the general public is more receptive to statements and claims of persons generally uninformed of actual conditions than to reports of the Commission's technical staff.

Petitions and complaints from over the state have asked that waters be returned to their natural condition and industries be required to discharge wastes as clean as the water receiving these wastes. Unfortunately, this position is taken by well-meaning and in many instances professional persons who are otherwise well informed, with no thought given to the utilization of the assimilative qualities of the waters. The feeling seemingly exists among many that the effectiveness of a water pollution control program should be measured by the number of orders issued and fines levied for the destruction of fish.

In searching for the reason of criticism of the Commission's water pollution control program, two possibilities appear to be the most plausible. First is the nationwide publicity given to water pollution, its effects and lack of control during recent years, and second is the provision of the state water pollution control law exempting waste discharges existing as of August 25, 1949, from regulation.

APPROACHES TO MORE EFFECTIVE WATER POLLUTION CONTROL

1. Legislation

a. State

It cannot be denied that 14 years is ample time for industries and municipalities, discharging wastes at the time of approval of the state water pollution law and privileged to continue discharging wastes at the same rate, to adjust to the basic requirements for

water pollution control. That such has not been done is evidence that some of those receiving this privilege do not intend to abate their pollution until required to do so. Under the circumstances, there is no alternative except to remove the provision of the law exempting pollution existing as of and prior to August 25, 1949, from the regulations. However, adequate time will be required to obtain compliance with the provisions incorporated in the amended law.

b. Federal

The Commission is on record in opposition to proposals to broaden the powers of the Federal government over water pollution control. The Commission feels that the Federal Water Pollution Control Act, in its present form, is adequate and provides the enforcement powers necessary for the Federal government to fulfill its responsibilities for protection of the quality of the nation's water resources.

2. Personnel

For reasons peculiar to Alabama, the Commission finds it extremely difficult to maintain an experienced and trained staff. There is a statutory limitation on the maximum salary that a classified employee in the service of the State of Alabama may be paid. This limitation is set at $11,000 per annum which means that only the ranking employee can receive this amount. Other employees must be paid less, irrespective of their qualifications and responsibilities.

3. Research and Study Projects

The knowledge of the effects of pollutional materials on water quality, especially fish, wildlife, aquatic life and humans, is not abreast with the technological advances being made by industry. Research is needed in the fields of industrial and municipal waste treatment directed toward the development of more efficient and economical methods of treatment. There are few, if any, state agencies equipped and staffed for research. Consequently, research requirements must be satisfied through other sources including industry, institutions and the Federal government.

In conclusion, the Commission feels the waters of Alabama are, on the whole, of good quality and that the state's water pollution control agency has been effective in preserving the quality of the waters in the best interests of the public. Our problems are internal and are such that can and must be solved at the state level. The Commission has, by its past actions, taken the stand that the existing state law must be amended to permit control and regulation of all sources of waste. We confidently feel that legislative action on this matter will be taken during the next regular session of the State Legislature.

NOTE: This is the final article in a series of three regarding the Alabama Water Improvement Commission's activities, responsibilities, and accomplishments as the state's water pollution control agency.

Pneumonia—The Disease That Was

Within the memory of most Americans the doctor's d r e a d e d diagnosis—pneumonia—meant days of anxious waiting for the "crisis" to come and go—if it did not prove fatal—and then weeks or months of convalescence. If the victim was the family breadwinner, it meant loss of work and income over a long period. Too often, pneumonia meant impoverishment for the family. Today, t h a n k s to new drug discoveries, most cases of pneumonia are quickly cured, and the costs, in drugs and loss of work, are minimal. It is the earnings of the pharmaceutical companies that support the massive research programs necessary to bring into being outstanding new drugs like those so useful in mastoiditis and pneumonia. —Alfred E. Driscoll, President, Warner-Lambert Pharmaceutical Company, in *New England Journal of Medicine,* 270: 6 (Feb. 6) 1964.

BUREAU OF LABORATORIES

Thomas S. Hosty, Ph.D., Director

September 1964

Examinations for intestinal parasites	1,432
Typhoid cultures (blood, feces, urine and other)	234
Brucella cultures	3
Examinations for malaria	4
Examinations for gonococci	1,942
Serologic tests for syphilis (blood and spinal fluid)	30,623
Darkfield examinations	4
Examinations for diphtheria bacilli and Vincent's	62
Complement fixation tests	67
Examinations for Negri bodies (smears and animal inoculations)	225
Water Examinations	2,397
Milk and dairy products examinations	3,773
Examinations for tubercle bacilli	3,563
Miscellaneous examinations	4,145
Total	48,474

* * *

BUREAU OF PREVENTABLE DISEASES

W. H. Y. Smith, M. D., Director

CURRENT MORBIDITY STATISTICS

1964

	Aug.	Sept.	*E. E. Sept.
Tuberculosis	134	92	155
Syphilis	148	126	108
Gonorrhea	453	257	334
Chancroid	5	1	2
Typhoid fever	0	1	4
Undulant fever	1	0	0
Amebic dysentery	8	11	2
Scarlet fever & strep. throat	212	224	55
Diphtheria	0	5	2
Whooping cough	19	18	23
Meningitis	4	8	6
Tularemia	0	0	0
Tetanus	1	1	2
Poliomyelitis	0	0	9
Encephalitis	1	0	2
Smallpox	0	0	0
Measles	64	24	15
Chickenpox	7	3	3
Mumps	35	15	15
Infectious hepatitis	36	42	25
Typhus fever	1	2	2
Malaria	0	0	0
Cancer	739	646	588
Pellagra	1	1	0
Rheumatic fever	15	10	12
Rheumatic heart	22	36	24
Influenza	9	35	35
Pneumonia	165	124	114
Rabies—Human cases	0	0	0
Pos. animal heads	1	1	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

BUREAU OF VITAL STATISTICS

Ralph W. Roberts, M. S., Director

PROVISIONAL BIRTH AND DEATH STATISTICS AND COMPARATIVE DATA, AUGUST 1964

Live Births / Deaths / Causes of Death	Number Registered During August 1964			Rates* (Annual Basis)		
	Total	White	Non-White	1964	1963	1962
Live Births	7,141	4,483	2,658	24.8	25.2	24.9
Deaths	2,429	1,596	833	8.4	8.2	8.0
Fetal Deaths	173	87	86	23.7	20.1	18.9
Infant Deaths—						
under one month	128	75	53	17.9	21.8	17.6
under one year	180	93	87	25.2	27.0	22.4
Maternal Deaths	3	1	2	4.1	6.8	1.4
Causes of Death						
Tuberculosis, 001-019	25	11	14	8.7	7.3	7.5
Syphilis, 020-029	5	2	3	1.7	1.0	0.7
Dysentery, 045-048	2		2	0.7		0.4
Diphtheria, 055	1		1	0.3	0.7	
Whooping cough, 056	1		1	0.3		
Meningococcal infections, 057	1		1	0.3	0.7	0.4
Poliomyelitis, 080, 081						0.4
Measles, 085						
Malignant neoplasms, 104-205	357	267	90	123.8	106.2	117.2
Diabetes mellitus, 260	33	15	18	11.4	11.2	10.7
Pellagra, 281						
Vascular lesions of central nervous system, 330-334	346	223	123	120.0	117.7	108.6
Rheumatic fever, 400-402					0.7	
Diseases of the heart, 410-443	751	528	223	260.4	269.9	263.2
Hypertension with heart disease, 440-443	106	39	67	36.8	35.6	48.8
Diseases of the arteries, 450-456	59	39	20	20.5	16.8	19.2
Influenza, 480-483	1	1		0.3	0.3	1.1
Pneumonia, all forms, 490-493	47	24	23	16.3	19.2	17.8
Bronchitis, 500-502	7	5	2	2.4		2.1
Appendicitis, 550-553	5	2	3	1.7	2.4	2.1
Intestinal obstruction and hernia, 560, 561, 570	13	7	6	4.5	5.6	4.3
Gastro-enteritis and colitis, under 2, 571.0, 764	11	1	10	3.8	6.3	2.8
Cirrhosis of liver, 581	19	19		6.6	6.3	7.5
Diseases of pregnancy and childbirth, 640-689	3	1	2	4.1	6.8	1.4
Congenital malformations, 750-759	33	23	10	4.6	3.7	3.0
Immaturity at birth, 774-776	37	17	20	5.2	6.7	4.4
Accidents, total, 800-962	181	137	44	62.8	62.2	55.2
Motor vehicle accidents, 810-835, 960	92	72	20	31.9	32.1	27.4
All other defined causes	346	221	125	120.0	118.7	120.8
Ill-defined and unknown causes, 780-793, 795	145	53	92	50.3	36.0	44.5

*Rates: Birth and death—per 1,000 population
Infant deaths—per 1,000 live births
Fetal deaths—per 1,000 deliveries
Maternal deaths—per 10,000 deliveries
Deaths from specified causes—per 100,000 population

The Woman's Auxiliary



Dear Doctor:

This is an open letter to your office force:

As the doctor's right-hand man, you have many problems to solve that were never taught in schools of nursing—or in secretarial school. For instance, there never was a course on keeping the office tidy after the mail comes in! After the boss has gone through his mail, you can throw away the "junk," but what about the drug samples?

Drug samples are useful. Without them the office force and the doctor's family would have to suffer through all human illnesses, unaided. But, let's face it, not all of the samples will be used for patients.

Your Scotch soul hates to see these valuable medicines wasted. What to do? Simple: Put them in a big box in the back room. When the box overflows, **don't** send them to the garbage can. Instead, call your doctor's wife, to get them. Chances are that her Auxiliary is collecting them to send to medical missionaries and hospitals overseas.

At collecting points, the medicines are checked and sorted by registered pharmacists, and experimental or outdated drugs are removed before they are packed for overseas shipment.

Who gets them? Hospitals and physicians in underdeveloped countries. They are thoroughly checked to make sure the need is bona fide, and that useful drugs will be sent to each.

Used medical textbooks (not more than 4 years old) and used medical journals are needed too. Write to:

Doctor-to-Doctor Program
World Medical Association
10 Columbus Circle,
New York, 19, New York

for the names of foreign physicians who have need for them. Sure, the shipment cost is up to your doctor (or the Medical Auxiliary), but it's a tremendous contribution to better medicine all over the world.

If, by chance, her Auxiliary isn't organized to do this for you, send them yourself:

World Medical Relief, Inc.
479 West Columbia Street
Detroit 1, Michigan

There, now! Don't you feel better? You've solved the problem of drug samples, and given yourself the good feeling of doing something for others. Congratulations.

Frances

Ghost written by Sylvia

Dr. R. G. Ford, who has been a resident in neurology in the Mayo Foundation in Rochester, Minnesota, has left that city and will be located in Birmingham, Alabama.

Dr. J. M. Garrett, who has been a resident in internal medicine in the Mayo Foundation in Rochester, Minnesota, has left that city and will be located in Birmingham, Alabama.

PEPTIC ULCER • FUNCTIONAL HYPERMOTILITY • IRRITABLE COLON

PYLOROSPASM • BILIARY DYSKINESIA • PANCREATITIS • URETERAL AND URINARY BLADDER SPASM • GASTRITIS



PYLOROSPASM • BILIARY DYSKINESIA • PANCREATITIS • URETERAL AND URINARY BLADDER SPASM • GASTRITIS

PRO-BANTHINE (propantheline bromide) Assures Authoritative Anticholinergic Control in Gastrointestinal Dysfunctions

The clear and consistent therapeutic benefits of Pro-Banthine (propantheline bromide) have made it the preferred anticholinergic for the past decade.

During that time, many compounds have been developed and proposed as alternatives. In the appraisal of Roach[1] "... few, if any, have seemed to offer a distinct improvement, ..."

Early investigations showed that Pro-Banthine (propantheline bromide) reduces motility and acid secretion and may be used in a wide range of dosage, to bring prompt, positive anticholinergic benefits to patients with peptic ulcer, spastic colon, pylorospasm and related gastrointestinal dysfunctions.

Recent evaluations sustain these earlier judgments. In a current authoritative assessment based mainly on the factors of potency, superiority to atropine, clinical experience and physiologic study, Steinberg and Almy[2] select as the first two preferred anticholinergic drugs, methantheline [Banthine] and propantheline [Pro-Banthine].

The name Pro-Banthine (propantheline bromide) sets a stamp of therapeutic authority on any anticholinergic prescription.

Side Effects and Precautions—Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur. The drug is contraindicated in patients with glaucoma or severe cardiac disease.

Dosage—The usual adult dosage is one tablet of 15 mg. with meals and two at bedtime; this amount may be doubled or tripled for patients with severe conditions. Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

SEARLE

Chicago, Illinois 60680

Research in the Service of Medicine

1. Roach, T. C.: Therapy of Peptic Ulcer, J. Louisiana Med. Soc. *115*:136-139 (April) 1963.
2. Steinberg, H., and Almy, T. P., Drugs for Gastrointestinal Disturbances, Chapter 21, in Modell, W. (editor): Drugs of Choice —1964-1965, St. Louis, The C. V. Mosby Company, 1964, p. 343.

PEPTIC ULCER • FUNCTIONAL HYPERMOTILITY • IRRITABLE COLON

PYLOROSPASM • BILIARY DYSKINESIA • PANCREATITIS • URETERAL AND URINARY BLADDER SPASM • GASTRITIS

too young to be so tired...

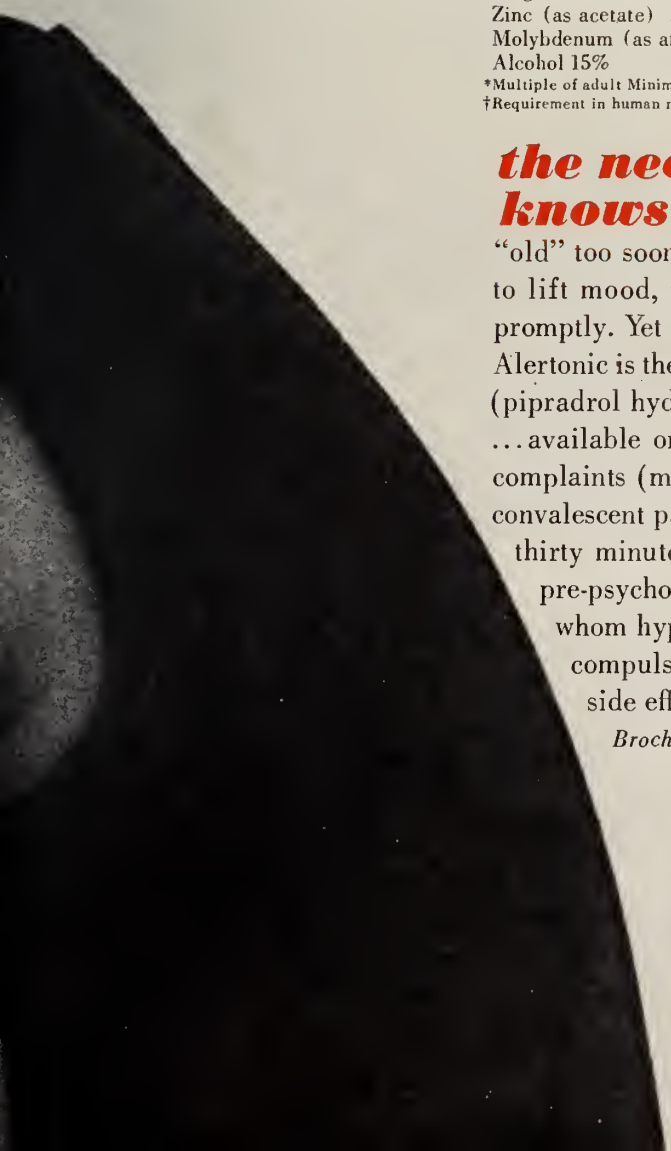


revive interest... restore activity promptly with

Alertonic®

Three tablespoonfuls (45 cc.) contain:		
Pipradrol hydrochloride		2 mg.
Vitamin B_1 (thiamine hydrochloride)	(10 MDR*)	10 mg.
Vitamin B_2 (riboflavin)	(4 MDR*)	5 mg.
Vitamin B_6 (pyridoxine hydrochloride)		1 mg.
Nicotinamide	(5 MDR*)	50 mg.
Choline†		100 mg.
Inositol†		100 mg.
Calcium glycerophosphate	(2% MDR for calcium and phosphorus)	100 mg.
Cobalt (as chloride)		1 mg.
Manganese (as sulfate)		1 mg.
Magnesium (as acetate)		1 mg.
Zinc (as acetate)		1 mg.
Molybdenum (as ammonium molybdate)		1 mg.
Alcohol 15%		

*Multiple of adult Minimum Daily Requirement supplied
†Requirement in human nutrition not yet established



the need for a tonic knows no age

Anyone can feel tired and "old" too soon. In such functional fatigue, Alertonic helps to lift mood, revive interest, restore purposeful activity promptly. Yet it contains no MAO inhibitors, no hormones. Alertonic is the effective formulation of a cerebral stimulant (pipradrol hydrochloride), alcohol, vitamins, and minerals ...available on prescription *only*. For common functional complaints (mild mood depression, tiredness); geriatric or convalescent patients, Rx one *tablespoonful* Alertonic *t.i.d.*, thirty minutes before meals. Contraindicated in agitated pre-psychotic patients, paranoia, or other patients in whom hyperexcitability, anxiety, chorea, or obsessive-compulsive states are present. Mild central stimulant side effects may occasionally occur.

Brochure with full product information available on request.

Merrell

THE WM. S. MERRELL COMPANY
Division of Richardson-Merrell Inc.
Cincinnati, Ohio / Weston, Ontario

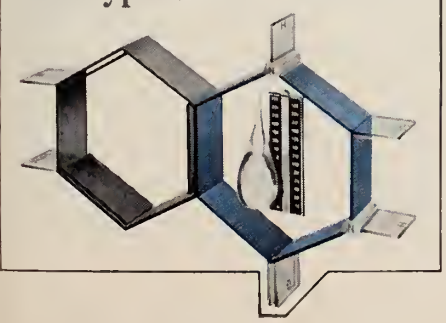


Just turned hypertensive

A 15 mm. Hg drop in diastolic pressure would also suit her very well

For suitably gradual, physiologic hypotensive treatment

HYDROMOX®
QUINETHAZONE · TABLETS
antihypertensive diuretic



HYDROMOX Quinethazone is excellent for use in early hypertension. Extremely well tolerated, the average reported reduction in diastolic pressure is 15 mm. Hg,[1,2] just right for patients with mild to moderate diastolic elevations. Systolic pressure lowered accordingly. A convenient, single daily dose of one to two 50 mg. tablets is usually sufficient.

INDICATED in hypertension with or without edema, and in all types of edema involving salt retention. May be helpful in some cases of lymphedema, idiopathic edema and edema due to venous obstruction.

SIDE EFFECTS: Skin rash (rare), gastrointestinal disturbances, weakness and dizziness, seldom so severe that drug should be stopped. Generally, the adverse effects sometimes associated with the thiazide diuretics are possible. Pre-existing electrolyte abnormalities may be aggravated.

CONTRAINDICATION: Anuria.

1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. J. Amer. Geriat. Soc. 11:945 (Oct.) 1963.

2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N.Y. Lederle

8370-4



Of special significance to the physician is the symbol

When he sees it engraved on a Tablet of Quinidine Sulfate he has the assurance that the Quinidine Sulfate is produced from Cinchona Bark, is alkaloidally standardized, and therefore of unvarying activity and quality.

When the physician writes "DR" (Davies, Rose) on his prescriptions for Tablets Quinidine Sulfate he is assured that this "quality" tablet is dispensed to his patient.

Rx Tablets Quinidine Sulfate Natural
0.2 Gram (or 3 grains)
Davies, Rose

Clinical samples sent to physicians upon their request

Davies, Rose & Company, Limited
Boston 18, Mass.

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"Gesundheit!"

...is just for the sneeze

but for symptomatic relief of the common cold...

'EMPRAZIL'®

TABLETS

Each layered tablet contains:

'Sudafed'® brand Pseudoephedrine Hydrochloride	20 mg.
'Perazil'® brand Chlorcyclizine Hydrochloride	15 mg.
Phenacetin	150 mg.
Aspirin	200 mg.
Caffeine	30 mg.

To relieve the aches, pains, fever and respiratory congestion of the common cold, flu or grippe with one product ...specify 'Emprazil'.

Caution: While pseudoephedrine is virtually without pressor effect in normotensive patients, it should be used with caution in hypertension. Also, while chlorcyclizine has a low incidence of antihistaminic drowsiness, the usual precautions should be observed.

Supplied: Bottles of 100 and 1000.

Also available with codeine—on prescription only—as **'EMPRAZIL-C'®** tablets

Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.



Outwardly calm...but what goes on inside?

Appearances on the outside do not necessarily suggest what goes on inside. This is particularly true of the ulcer patient, who may appear jolly and unruffled to his neighbors, but presents to you the classic symptoms: organic and functional disorders of the G.I. tract, associated with anxiety and tension.

Consider, when you see him next, the value of PATHILON® SEQUELS® with Phenobarbital, which provides sustained anticholinergic protection from spasm and pain in the target areas, as well as sustained phenobarbital action against triggering anxiety. The controlled release of the active ingredients in the SEQUELS® formulation means protective medication day and night.

Effective in peptic ulcer, intestinal colic, ileitis, esophageal spasm, spastic colon, alcohol-induced G.I. upsets, gastric hypermotility and anxiety neurosis with G.I. symptoms. Should be used as adjunct to other measures.

Side Effects (due to tridihexethyl chloride): dry mouth, blurring of vision, constipation.

Contraindications: urinary bladder neck obstruction; glaucoma; obstructive congenital anomalies of the gastrointestinal tract; pyloric obstruction; congenital megacolon; and stenosing gastric or duodenal ulcer with significant gastric retention.

Also available, without phenobarbital, as PATHILON® Tridihexethyl chloride SEQUELS® 75 mg.

Pathilon® Sequels® with Phenobarbital Sustained Release Capsules

Each capsule contains: Tridihexethyl chloride, 75 mg., and phenobarbital, 45 mg.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle

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"feels wonderful...cleared head entirely"

(clearly decongested with Dimetapp)



Dimetapp® Extentabs®

(Dimetane®[brompheniramine maleate], 12 mg.; Phenylephrine hydrochloride 15 mg.; Phenylpropanolamine hydrochloride, 15 mg.)

In sinusitis, colds, U.R.I., Dimetapp lets your "stuffed-up" patients *breathe easy again.* Each long-acting Extentab provides clear relief for up to 10-12 hours, yet seldom causes drowsiness or overstimulation.

BRIEF SUMMARY: ***Indications:*** Dimetapp reduces nasal secretions, congestion, and postnasal drip for symptomatic relief of colds, U.R.I., sinusitis, and rhinitis. ***Side Effects:*** In high dosages, occasional drowsiness due to the antihistamine or CNS stimulation due to the sympathomimetics may be observed. ***Precautions:*** Administer with caution in the presence of cardiac or peripheral vascular diseases and hypertension. ***Contraindications:*** Antihistamine sensitivity. Not recommended for use during pregnancy.

*Clinical report on file, Medical Department, A.H. Robins Co., Inc.

A.H. ROBINS CO., INC., RICHMOND 20, VA.



THE ULCER LIFE

In this "pop art" assemblage, artist Bob Sullivan depicts "the ulcer life" as man-in-a-box. The wall of nails closing in might well symbolize the torturous demands of a rigid, conformist society. As for the man, his disembodied psyche moves relentlessly onward with the blank, fixed stare of a man who has lost control of his own destiny. Small wonder that his gastric mechanism rebels.

NUMBER 1 IN A SERIES

for the ulcer life:
a new strength of glycopyrrolate

ROBINUL® FORTE
2 mg. per tablet

ROBINUL®-PH FORTE
glycopyrrolate 2 mg. phenobarbital 16.2 mg. (warning: may be habit forming)

When glycopyrrolate was first introduced, clinicians were immediately impressed by the remarkable ability of this compound to exert a more specific pharmacologic action on the gastrointestinal tract than on other organ systems. For example, they often found that in difficult patients the dosage could easily be adjusted upwards to achieve the desired suppression of both hypertonicity and secretion . . . without paying the penalty of side effects intolerable to the patient. Thus, it is no surprise that many clinicians suggested that a double-strength 2 mg. tablet of glycopyrrolate would be both practical and useful. For those patients ordinarily unresponsive to anticholinergics or for those exhibiting the more prominent symptoms, the new Forte dosage forms are a worthwhile addition to your ulcer armamentarium.

BRIEF SUMMARY

INDICATIONS: In addition to its primary indications for duodenal and gastric ulcer, glycopyrrolate is indicated for other G-I conditions which may benefit from anticholinergic therapy. Robinul-PH Forte (glycopyrrolate 2 mg. with phenobarbital) is indicated when these situations are complicated by mild anxiety and tension.

CONTRAINDICATIONS: Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte, sensitivity to phenobarbital.

PRECAUTIONS: Administer with caution in the presence of incipient glaucoma.

SIDE EFFECTS: Dryness of mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.

DOSAGE: Should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet three times a day: in the a.m., early p.m., and at bedtime.

See product literature for full prescribing information.

Statement of Ownership, Management and Circulation

(Act of October 23, 1962; Section 4369, Title 39, United States Code)

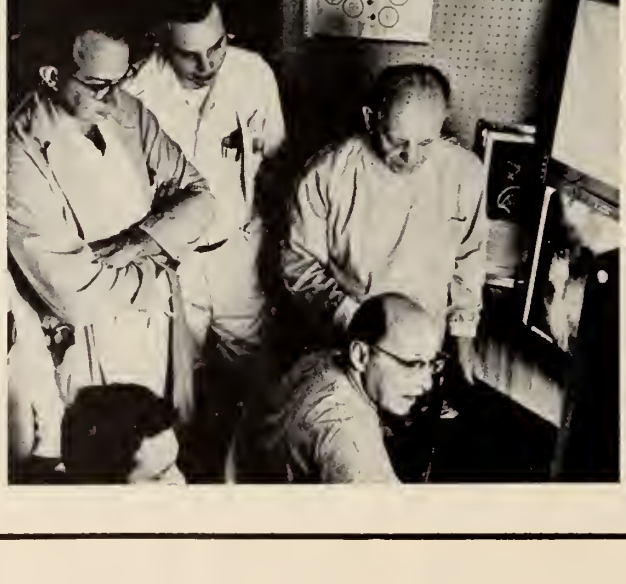
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Wm. L. Smith, M. D., Editor

Your investment
In the Future
Of Medicine



A gift to medical education through AMA-ERF

Your contribution to the Funds for Medical Schools of AMA-Education and Research Foundation can help to guarantee the continuing high quality of American medicine. You may designate your gift for a specific school or give to all of the nation's accredited medical schools. All contributions to AMA-ERF are tax deductible. Mail your check to:

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for you and your patients...

greater bacteriostatic protection than with any other leading antibacterial bar soap... new Safeguard



New Safeguard provides the regular user with greater sustained reduction of skin bacteria than any other leading antibacterial bar soap. This heightened effectiveness is achieved through a more potent, yet excellently tolerated combination of antibacterial agents.* Exhaustive laboratory and clinical tests have proved Safeguard's...

- **superior residual bacteriostatic effect**
- **superior control of S. aureus**
- **unsurpassed safety and mildness**

*Safeguard contains 3,5-di- and 3,4',5-tribromosalicylanilides, 4,4'-dichloro-3- (trifluoromethyl) carbanilide, and 3,4,4'-trichlorocarbanilide.

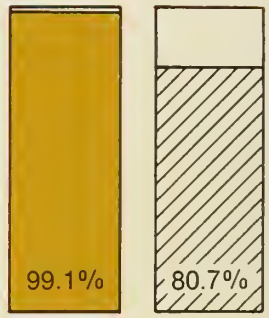
here are the facts on Safeguard's superior antibacterial effectiveness

The superior antibacterial action of Safeguard has been demonstrated by a variety of techniques. Below are some of the comparative results obtained with Safeguard ▬ and another leading deodorant and antibacterial bar soap containing 0.5% hexachlorophene and 0.5% 3,4,4'-trichlorocarbanilide. ▨

superior residual antibacterial effect proved by handwashing tests

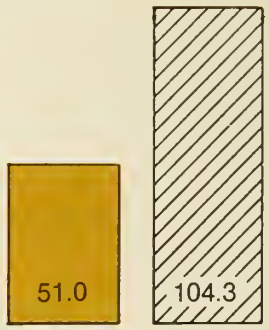
In a modified Price multiple washbasin procedure, Safeguard attained an average reduction of 99.1% in the number of organisms recoverable from the final rinse water, as compared to an average of 80.7% for the other antibacterial bar soap tested. Both products had been used exclusively for four days prior to evaluation.

Safeguard has also proved its superior residual bacteriostasis in field tests conducted under everyday household conditions as measured by a simplified washbasin technique.



superior residual antibacterial effect confirmed by skin stripping technique

Safeguard and the other antibacterial bar soap were used for normal everyday toilet purposes by a group of housewives for 14 days. Layers of superficial skin cells were then taken by a stripping technique to determine the density of the bacterial population. The average count per 2.25 sq. cm. for Safeguard was 51.0 while the finding for the other antibacterial bar was 104.3—more than double Safeguard's reading.



superior control of S. aureus demonstrated in laboratory and field tests

In vitro serial dilution tests with **S. aureus** showed Safeguard to inhibit growth at a minimal concentration of 3 p.p.m. while the other antibacterial bar soap required 4 p.p.m. to produce this effect. Interestingly enough, a leading surgical scrub liquid detergent containing 3% hexachlorophene was inhibitory at 7 p.p.m. in this instance. With two antibiotic resistant strains of **S. aureus,** Safeguard maintained its level of effectiveness. **In vivo** studies have also demonstrated Safeguard's superiority in reducing the number of persons carrying this potential pathogen.

testing has provided extensive evidence of Safeguard's mildness and safety

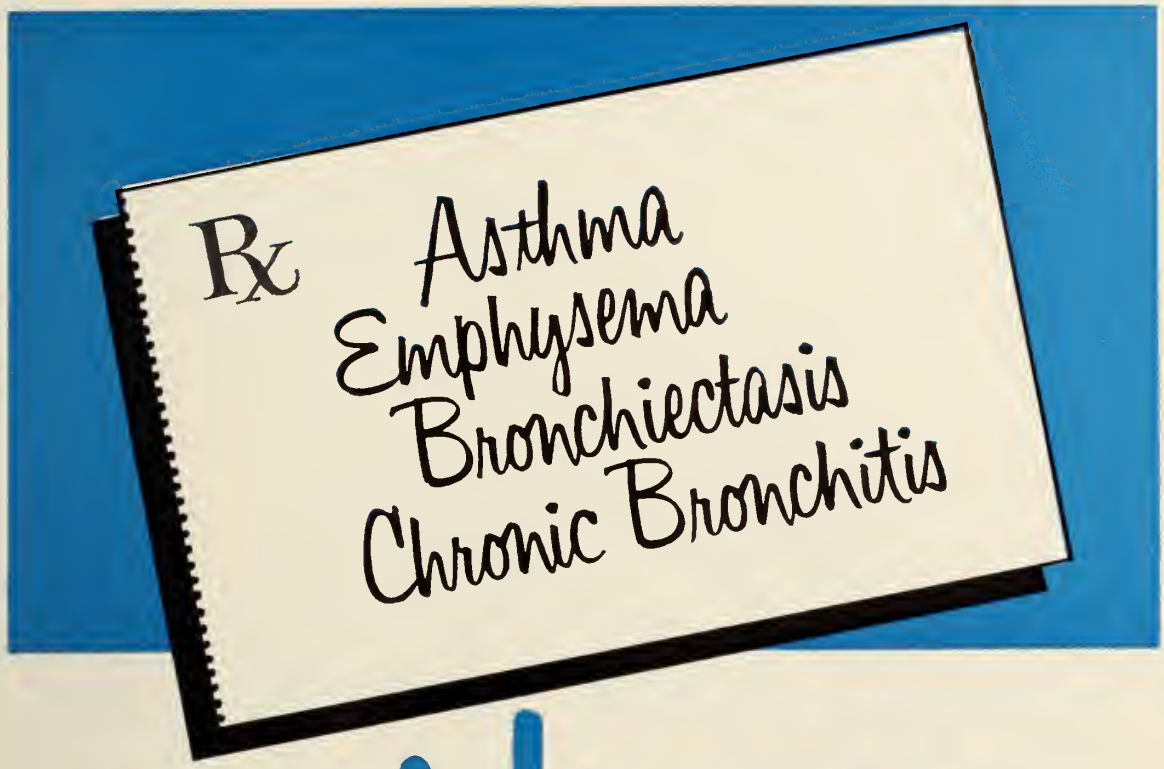
Repeat patch testing and careful professional observation of the skin of regular users has shown that Safeguard is as mild as any other quality toilet soap—as suitable for the nursery as for the operating room. Exhaustive tests have also documented the safety of its antibacterial components.

SAFEGUARD'S IMPORTANCE TO YOU.. Safeguard's superior antibacterial effect makes it of particular value to physicians and nurses because of their greater than average exposure to pathogenic organisms.

For further information please write to: Director of Medical Programs, P.O. Box 599. PROCTER & GAMBLE, CINCINNATI, OHIO 45201

Safeguard
NEW DEODORANT AND ANTI-BACTERIAL SOAP

002R64



mudrane®

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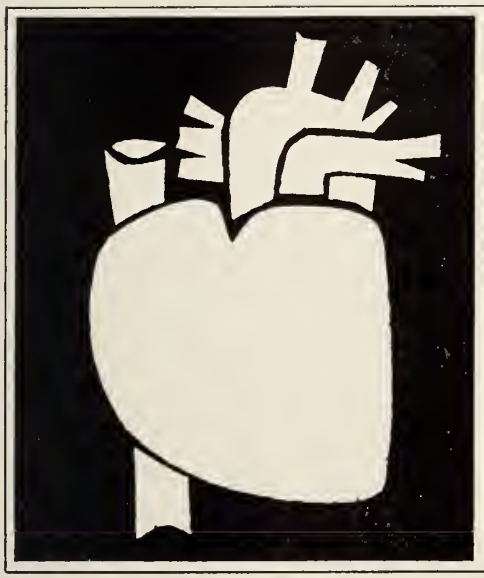
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1. Dorfman, W., and Johnson, D.: *Overweight Is Curable*, New York, The Macmillan Company, 1948, p. 16.

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REFERENCES: 1. Collicelli, A., and Nardelli, A.: Treatment of angina pectoris with a combination of pentaerythritol tetranitrate and meprobamate. Policlinico (Prat.) 67:441, Mar. 28, 1960. **2.** Marche, J.: Pentaerythritol tetranitrate (pentrite or pentanitrine)—a coronary vasodilator with prolonged action. J. Med. Chir. Prat. (In French) 121:252, Nov. 1950. **3.** Plotz, M.: Pentaerythritol tetranitrate: A new drug for the treatment of coronary insufficiency. N. Y. J. Med. 52:2012, Aug. 15, 1952. **4.** Plotz, M.: The treatment of angina pectoris with a new prolonged action pentaerythritol tetranitrate. Amer. J. Med. Sci. 239:194, Feb. 1960. **5.** Russek, H. I., Urback, K. F., Doerner, A. A. and Zohman, B. L.: Choice of a coronary vasodilator drug in clinical practice. JAMA 153:207, Sept. 19, 1953. **6.** Russek, H. I., Zohman, B. L. and Dorset, V. J.: Objective evaluation of coronary vasodilator drugs. Amer. J. Med. Sci. 229:46, Jan. 1955. **7.** Russek, H. I., Zohman, B. L., Drumm, A. E., Weingarten, W. and Dorset, V. J.: Long-acting coronary vasodilator drugs: Metamine, Paveril, Nitroglyn, and Peritrate. Circulation 12:169, Aug. 1955. **8.** Russek, H. I.: Evaluation of drugs used in the treatment of angina pectoris by means of exercise-electrocardiographic tests. Ann. N. Y. Acad. Sci. 64:533, Nov. 16, 1956. **9.** Talley, R. W., Beard, D. W., and Doherty, J. E.: Use of pentaerythritol tetranitrate (Peritrate) in treatment of angina pectoris. Amer. Heart J. 44:866, Dec. 1952. **10.** Winsor, T. and Humphreys, P.: Influence of pentaerythritol tetranitrate (Peritrate) on acute and chronic coronary insufficiency. Angiol. 3:1, Feb. 1952. **11.** Eskwith, I. S.: Holistic approach in the management of angina pectoris. Postgrad. Med. 27:203, Feb. 1960. **12.** Friedlander, H. S.: The role of ataraxics in cardiology. J. Cardiol. 1:395, Mar. 1958. **13.** Russek, H. I.: Meprobamate in the treatment of angina pectoris. Amer. J. Cardiol. 3:547, Apr. 1959. **14.** Shapiro, S: Observations on the use of meprobamate in cardiovascular disorders. Angiol. 8:504, Dec. 1957. **15.** Waldman, S. and Pelner, L.: Modification of the anxiety state associated with myocardial infarction by meprobamate: preliminary notes. N. Y. J. Med. 58:1285, Apr. 15, 1958. **16.** Koehnke, F. K.: Treatment of angina pectoris of functional origin with Corneural. Med. Klin. 54:1435, Aug. 1959.

Indications: 'Miltrate' is useful for prophylaxis of pain in angina pectoris and coronary insufficiency, especially where anxiety is a factor. **Contraindications:** Like all nitrates, pentaerythritol tetranitrate should be avoided or prescribed cautiously for patients with glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use. **Precautions:** *Meprobamate* —Patients engaged in activities requiring alertness should be warned of drowsiness. Meprobamate may increase the effects of excessive alcohol, and the possibility of dependence should be considered, particularly in patients with a history of drug or alcohol addiction. Sudden withdrawal may result in reactions, rarely epileptiform seizures. Grand mal attacks may be precipitated in persons susceptible to both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies. **Side effects:** *Pentaerythritol tetranitrate* —The most common side effects are transient headache, nausea, and rash. Weakness, palpitation, flushing, gastrointestinal distress, and lightheadedness have been reported on a few occasions. *Meprobamate* —May cause drowsiness and, rarely, ataxia, usually controlled by decreasing the dosage. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses of the drug. Mild reactions include urticarial or maculopapular rash. Serious reactions, rarely encountered, include dermatological effects, acute nonthrombocytopenic purpura, chills, fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises, anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic, and the drug not be reinstituted. **Dosage:** Usual dosage is one or two tablets before meals and at bedtime. Individualization of dosage is required for maximum therapeutic effect. Doses above twelve tablets daily are not recommended. **Supplied:** White tablets, each containing meprobamate 200 mg. and pentaerythritol tetranitrate 10 mg. ***Before prescribing, consult package circular.***

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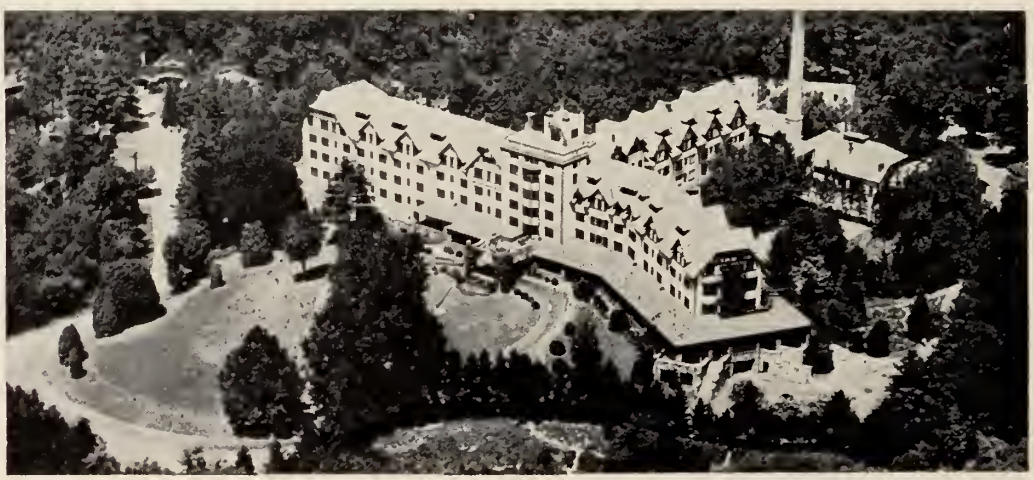
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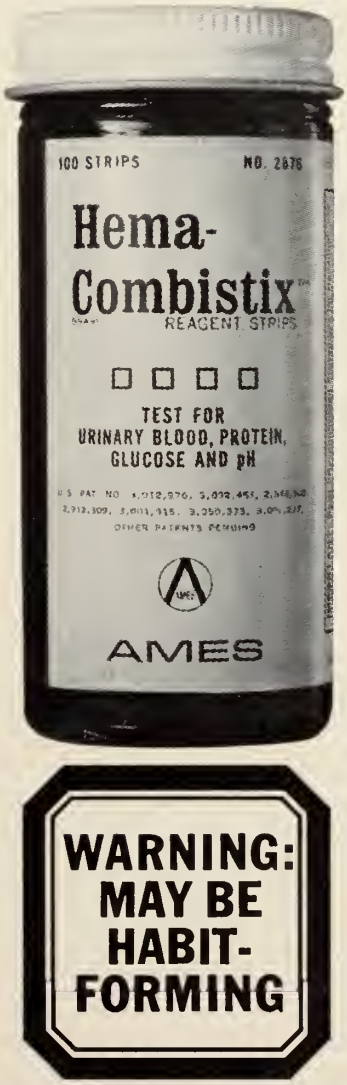
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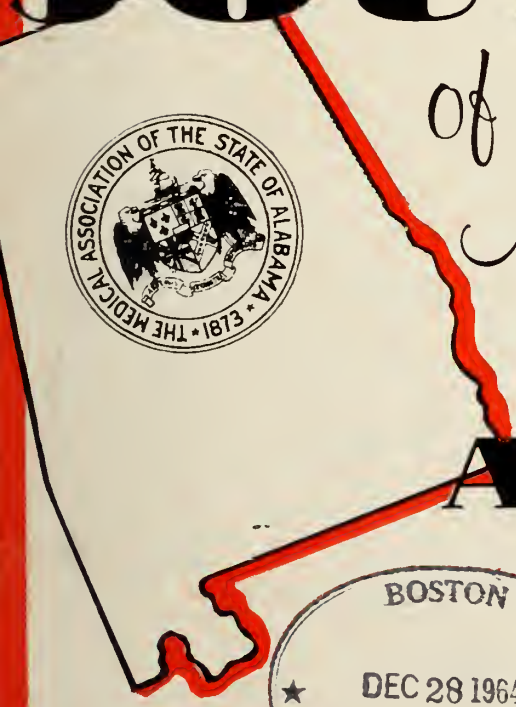
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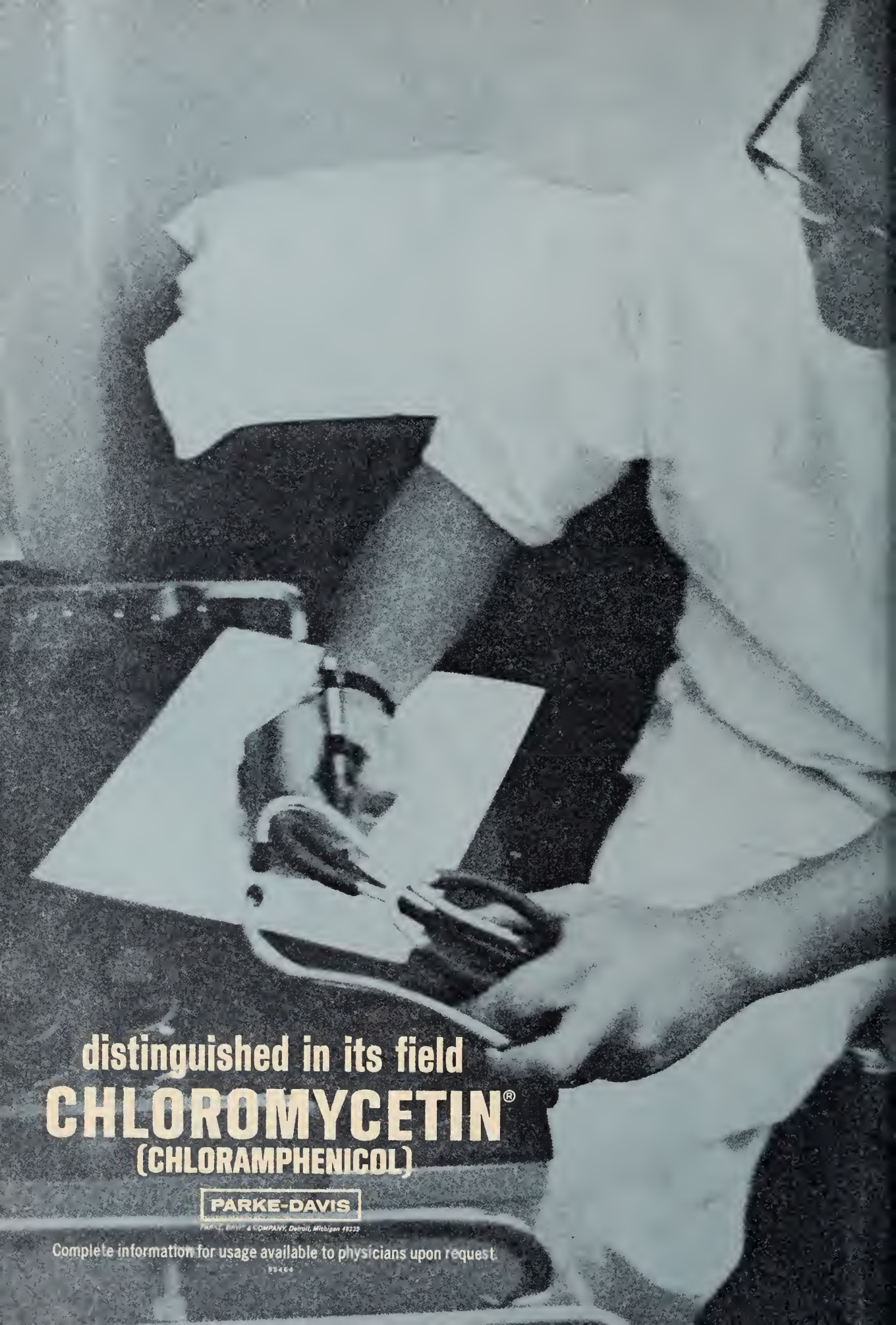
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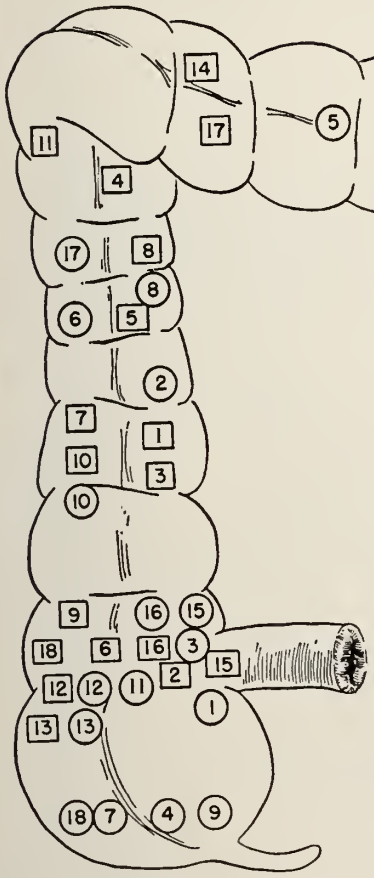


Figure 3-25. *Location of cancer and simple adenomas in resected cancers of the right colon. Squares locate cancers; circles, adenomas.*

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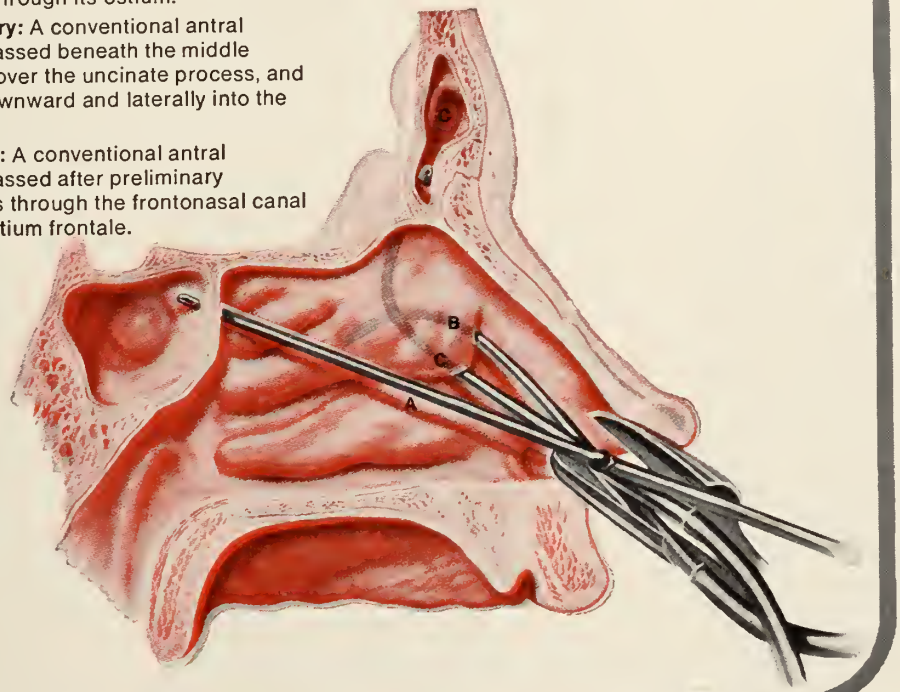
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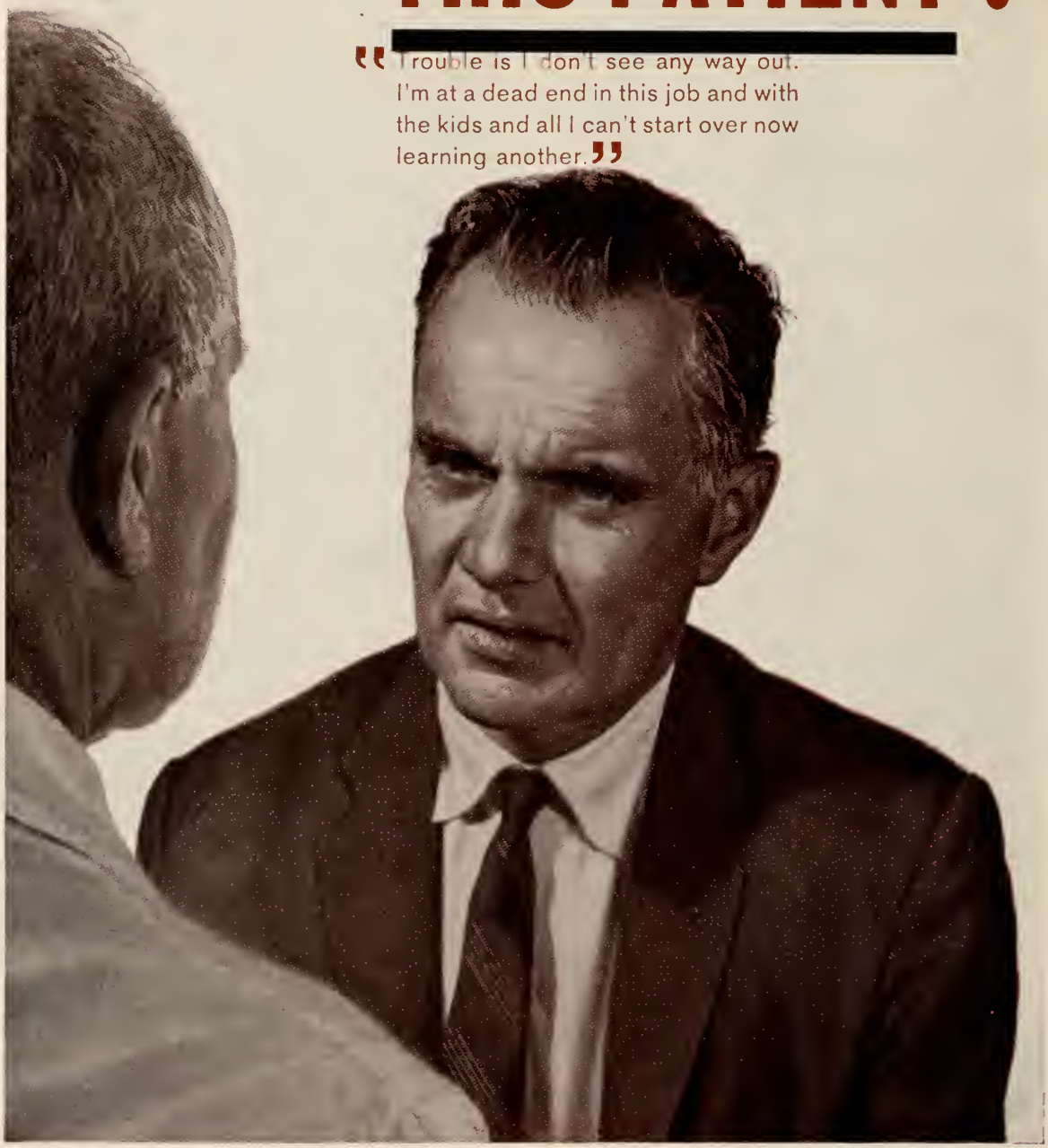
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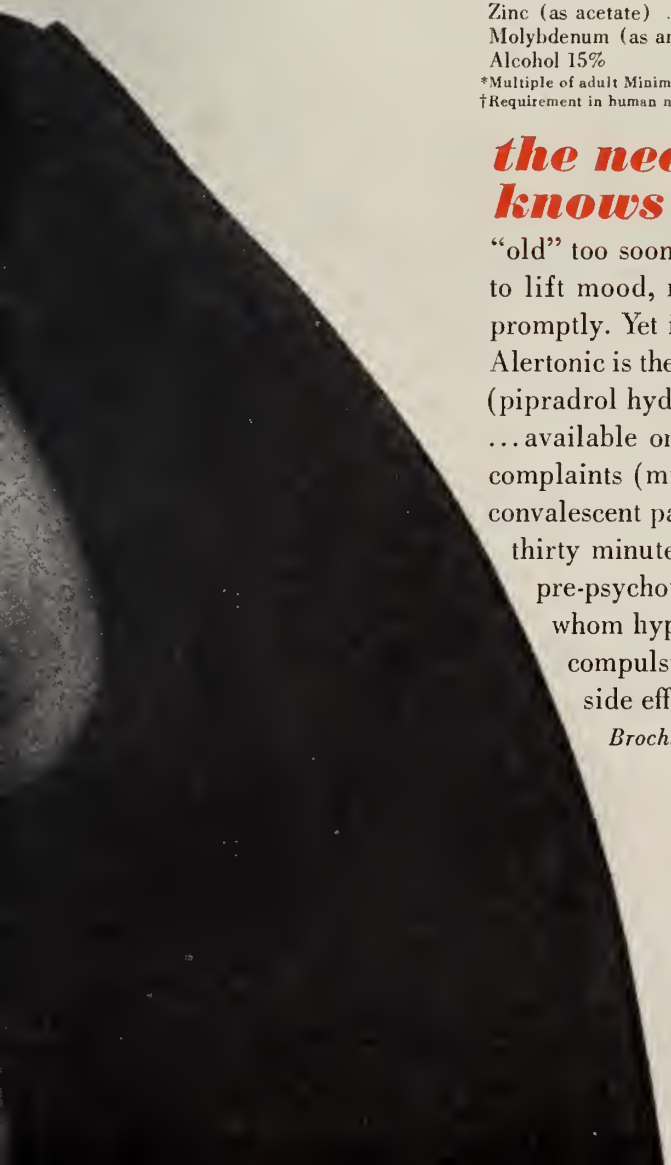


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[1] *Bibby, Basil G. D.M.D., PH.D., et al "Evaluation of Caries-Producing Potentialities of Various Foodstuffs" Jt of Am Dent Assn; vol 42, May '51, pps 491-509*

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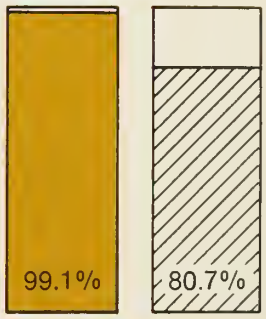
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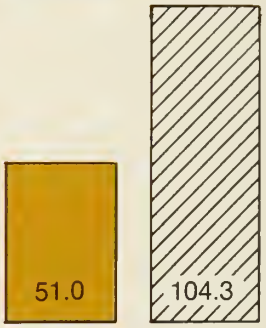
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Born January 20, 1862, at Gallion, Alabama, Eugene DuBose Bondurant attended the Avery School and Southern University, Greensboro, Alabama before enrolling in the School of Medicine of the University of Virginia in 1882.

He was graduated June 27, 1883, and was appointed Assistant Physician in the New York City Insane Hospital.

In 1885 Dr. Bondurant was appointed Assistant Physician of Alabama Hospital, Mobile, and later that year was named to the same post at the Alabama Insane Hospital by Dr. Peter Bryce. He became Assistant Superintendent of the Hospital in 1892.

Dr. Bondurant made his famous observations on Beriberi in 1895-1896. Endemic neuritis (Beriberi) was described by Osler (1892) in his textbook, *The Principles and Practice of Medicine*, as follows: ". . . This is a widely spread disease in parts of India, and in China and Japan . . . Great difference of opinion still prevails concerning the cause of this disease. It is probably due to a micro-organism. Food appears also to have a large share in its causation, and it has been attributed to a fish diet . . ."

This statement was repeated in the Second Edition of Osler's textbook. However, the Third Edition which appeared in 1898 carried the following statement:

". . . In 1895-1896, a remarkable outbreak of endemic neuritis occurred at the State Insane Hospital at Tuscaloosa, Alabama, which has been described by E. D. Bondurant. Between February 1895 and October 1896, in a population of 1,200 there were 71 cases with 21 deaths. None occurred among the 200 employees of the hospital. The Negroes were relatively less afflicted than the whites. The chief symptoms were muscular weakness, pain, parathesian loss of deep reflexes, followed by atrophy of muscles and the electrical reaction of degeneration accompanied by rise in temperature, gastro-intestinal disturbances, general anasarca and tachycardia." This statement was repeated in the next three editions of Dr. Osler's textbook.

In 1897 Dr. Bondurant joined the faculty



of the Medical College of Alabama as Chairman of Microscopy (including Histology, Pathology, and Bacteriology) and Nervous and Mental Diseases. In 1911 he was appointed dean, continuing to serve as Professor of Nervous and Mental Diseases.

He resigned in 1915 to become one of the first physicians in Alabama to enter the private practice of Psychiatry.

During World War I Dr. Bondurant commanded the Army General Hospital, Dan- lle, New York.

In World War II he was a member of the Medical Advisory Board of Mobile and administered Selective Service there from 1941 until 1945.

Dr. Bondurant served as president of the Tuscaloosa County Medical Society in 1893; secretary-treasurer in 1896-1897; and censor from 1892-1897.

After moving to Mobile he was vice-president of that county's society in 1903 and president in 1904. He served as censor from 1908 until 1912.

Dr. Bondurant was elected president of the Medical Association of the State of Alabama in 1905 and Senior Counsellor in 1928.

He was married to Miss Annie Laurie Prince in Mobile on April 19, 1899. They had no children.

Dr. Bondurant died in his 88th year on December 25, 1950. Mrs. Bondurant died a year and four days later.

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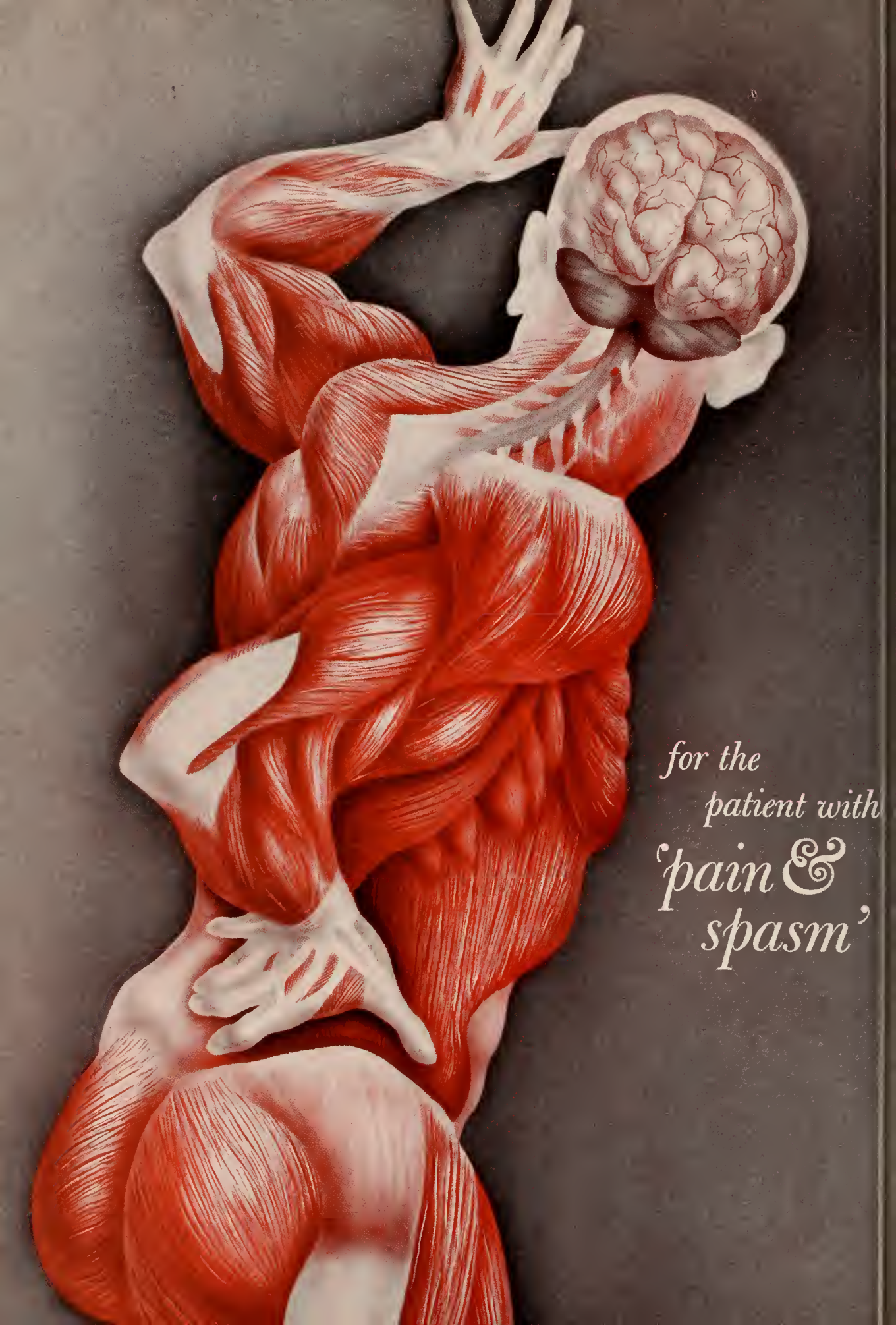
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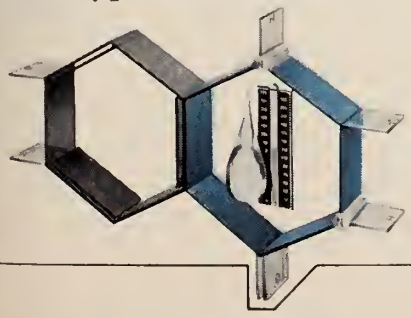
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CONTRAINDICATION: Anuria.

1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. J. Amer. Geriat. Soc. 11:945 (Oct.) 1963.

2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

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Furunculosis and Carbohydrate Metabolism

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and
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University Medical Center
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Introduction

Frequent reference appears in the literature[1-8] to the possible relationship of furunculosis to the diabetic state and hence to chronic hyperglycemia. As far as can be determined, there is: (1) no quantitative study of the correlation of furunculosis and hyperglycemia, and (2) no mention at all of the possible relationship of hypoglycemia and the chronic appearance of boils. It is the purpose of this report to attempt to cast some light on the possible relationship of furunculosis to carbohydrate metabolism (hyper- and hypoglycemia).

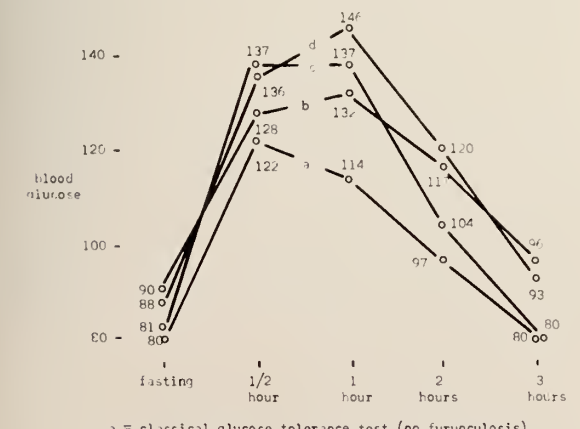


FIGURE 1

Table 1—age distribution

age groups	Group I number of subjects	Group I percentage of subjects	Group II number of subjects	Group II percentage of subjects
0-19	11	9	24	14
20-39	54	45	77	45
40-59	46	38	59	35
60-79	9	8	10	6
total	120	100	170	100

Method of Investigation

Two sets of patients participated in this project. Group I (120 subjects) were administered the classical glucose tolerance test.[9] The remaining 170 persons (Group II) were tested by means of the cortisone glucose tolerance procedure.[10] The age distribution is outlined (Table 1). It is clear that the pattern for the two groups is similar. Each patient was questioned regarding the occurrence of recurrent boils.

Table 2—significance of the differences of the symptomatic and asymptomatic patients

	no furunculosis	furunculosis	significance difference of means	significance difference of variance
Group I				
fasting	80 ± 20	90 ± 44	>0.050	=0.001
½ hour	112 ± 34	128 ± 58	=0.500	=0.001
1 hour	114 ± 48	132 ± 81	>0.100	=0.001
2 hours	97 ± 48	117 ± 81	>0.050	=0.001
3 hours	80 ± 41	96 ± 75	>0.100	=0.001
Group II				
fasting	81 ± 15	88 ± 14	>0.100	=0.500
½ hour	137 ± 32	136 ± 26	=0.500	=0.500
1 hour	137 ± 45	146 ± 40	=0.500	=0.500
2 hours	104 ± 38	120 ± 42	>0.100	=0.500
3 hours	80 ± 34	93 ± 31	>0.200	=0.500

Results

Figure 1 charts the mean blood glucose values for the two groups and for their symptomatic and asymptomatic subgroups. At every temporal point but one (thirty minute determinations in Group II), the mean blood glucose for the patients without boils is lower than for those with furuncles. However, an examination of Table 2 shows that, in all cases, the differences of the means are statistically not significant.

A more detailed study of Table 2 shows that, while the means are not significantly different, the spread of the scores about the means in Group I may be somewhat greater in the symptomatic versus the asymptomatic subgroups. Table 2 demonstrates that the variance differs significantly (P=0.001) at every temporal point in the Group I subjects.

Discussion

It is recognized that the clinical measurement is crude. However, interrogating the patient is the only available technique for eliciting a past history of furunculosis. Perhaps, in one sense, this makes the story more interesting since these findings are obtained in the face of so indelicate a measuring stick.

All in all, the data described here thus far are in agreement with other published reports.[11-14] Hence, the consensus today is that few if any significant relationships prevail between furunculosis and diabetes mellitus as derived from a consideration of the significance of the difference of the means.

It is reasonable to assume that many and diverse factors may be part of the genesis of furunculosis. In an attempt to restudy boils in more homogeneous samples, paired subgroups were randomly selected from the original two groups. Table 3 provides the original data and emphasizes the fact that the pairing was done on the basis of age and sex.

Figure 2 represents the blood glucose values for the two paired groups and for their symptomatic and asymptomatic subgroups. At every temporal point, at least in Group I, the mean blood glucose is lower for the asymptomatic group. This pattern, it should be recalled, is very similar to that noted for the entire sample described earlier.

An examination of Table 4 shows that, in all instances, the differences of the means are statistically not significant. These findings are also the same as previously noted in Table 2.

A more detailed study of Table 4 shows that, while the means are not significantly different, the spread of the scores about the means may be somewhat greater in the

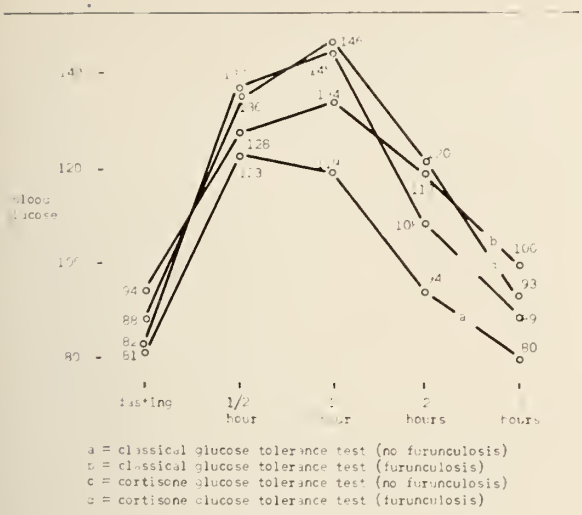


FIGURE 2

symptomatic versus the asymptomatic subgroups in Group 1. Table 4 demonstrates that the variance differs significantly in four of the five temporal measurements with the classical glucose tolerance test.

It would appear, within the limits of this study, that the issue is not really one of the relationship of furunculosis to diabetes mellitus. In other words, the problem does not appear to be one of noting the frequency of recurrent boils in hyper- versus normoglycemic individuals. Rather, the discussion centers about the relationship of furunculosis to carbohydrate metabolism. Viewing the problem in a trichotomy (hyper-, normo-, and hypoglycemia) makes possible an entirely different interpretation and seemingly more meaningful conclusion. It seems that the absence of furuncles is paralleled by a relatively restricted blood glucose range (more narrow in terms of conventional standards). Conversely, furunculosis seems more likely to be associated with both hyper- and hypoglycemia as judged from the analysis of the variance especially in Group 1. Thus, the different interpretation here as against other reports is found in the fact that heretofore a dichotomy has been employed. In such a

Table 3—original paired data of patients with and without furunculosis studied by means of the classical and cortisone glucose tolerance tests

classical glucose tolerance test

group without boils								group with boils							
case number	age	sex	fast	½ hr	1 hr	2 hrs	3 hrs	case number	age	sex	fast	½ hr	1 hr	2 hrs	3 hrs
534	17	F	76	91	95	35	56	609	16	F	80	107	100	107	97
580	19	F	95	63	97	115	74	535	19	F	73	63	55	60	55
612	22	M	75	128	152	120	93	597	21	M	65	110	95	85	63
496	23	M	90	135	112	80	63	589	23	M	75	110	75	60	48
501	24	F	75	135	97	53	73	502	24	F	80	110	114	120	95
599	28	F	60	81	90	81	65	499	28	F	75	73	70	73	67
592	29	M	60	100	90	65	57	562	29	M	79	157	204	97	63
530	31	F	83	85	73	73	73	542	31	F	220	296	360	406	350
539	32	M	70	107	104	70	65	610	32	M	80	105	107	85	45
528	34	F	74	120	55	51	48	504	33	F	110	150	175	104	90
587	35	F	63	95	73	68	82	500	35	F	83	107	104	90	100
525	37	F	73	80	95	76	70	507	37	F	80	63	105	85	88
529	38	F	65	143	97	63	67	524	38	F	65	110	106	65	50
512	38	M	82	117	104	63	68	532	39	M	74	114	110	74	45
511	39	F	99	150	134	132	82	526	39	F	70	150	117	88	35
519	43	F	75	120	120	74	74	536	43	F	82	60	73	79	76
600	43	F	74	114	125	117	70	593	43	F	270	330	430	380	364
590	48	F	180	235	306	340	306	561	48	F	95	120	125	115	97
584	49	F	88	135	132	114	91	583	49	F	68	85	68	70	60
493	50	F	80	180	178	100	60	495	50	F	85	123	105	85	90
523	52	F	75	155	175	117	57	537	52	F	82	133	130	130	104
571	59	F	70	125	107	76	44	565	58	F	75	107	135	132	100
563	61	F	75	140	133	90	95	494	60	F	85	157	125	155	115
mean			81	123	119	94	80				94	128	134	119	100
S.D.			24	37	51	59	51				49	65	89	90	84

Table 3 (continued)—original paired data of patients with and without furunculosis studied by means of the classical and cortisone glucose tolerance tests

cortisone glucose tolerance test

group without boils								group with boils							
case number	age	sex	fast	½ hr	1 hr	2 hrs	3 hrs	case number	age	sex	fast	½ hr	1 hr	2 hrs	3 hrs
46	16	M	75	115	105	83	50	160	17	M	63	115	118	77	68
165	33	F	70	103	133	85	77	143	33	F	85	120	153	115	118
87	34	F	80	128	140	115	98	39	34	F	95	135	130	107	60
130	35	F	80	133	135	93	68	9	35	F	98	132	125	125	93
56	38	F	98	118	135	85	80	147	38	F	63	107	77	50	38
170	39	F	85	147	185	110	95	100	39	F	85	125	180	160	140
169	43	F	70	140	203	207	227	81	43	F	92	120	117	110	85
17	46	F	95	165	162	99	90	153	46	F	87	142	147	120	100
3	48	F	75	130	115	98	74	73	48	F	107	198	225	210	140
104	52	F	85	147	125	100	68	59	52	F	95	135	150	100	90
21	54	M	85	180	157	115	57	4	53	M	99	170	180	148	95
mean			82	137	145	108	87				88	136	146	120	93
S.D.			9	22	29	35	48				14	26	40	42	31

binomial system, the hypoglycemic case obviously is absorbed into the normoglycemic group. This concept can be better portrayed in pictorial fashion.

Figure 3 shows the individual patients' values under fasting conditions with the classical glucose tolerance test. Table 4 indicates that there is no statistically significant difference of the means ($P>0.200$). However, it is clear from Figure 3 that the variance is much greater in the symptomatic subjects and this is confirmed in Table 4 ($P=0.010$).

Summary

1. Two hundred and ninety patients were questioned regarding the absence or presence of furunculosis. One hundred and twenty individuals (Group I) were examined by the classical glucose tolerance test and the re-

Table 4—significance of the differences of the symptomatic and asymptomatic paired patients

	no furunculosis	furunculosis	significance difference of means	significance difference of variance
Group I				
fasting	81 ± 24	94 ± 49	>0.200	=0.010
½ hour	123 ± 37	128 ± 65	=0.500	=0.020
1 hour	119 ± 51	134 ± 89	>0.400	=0.020
2 hours	94 ± 59	119 ± 90	>0.200	=0.100
3 hours	80 ± 51	100 ± 84	>0.200	=0.050
Group II				
fasting	82 ± 9	88 ± 14	>0.200	=0.200
½ hour	137 ± 22	136 ± 26	=0.500	=0.500
1 hour	145 ± 29	146 ± 40	=0.500	=0.500
2 hours	108 ± 35	120 ± 42	>0.400	=0.500
3 hours	89 ± 48	93 ± 31	=0.500	=0.200

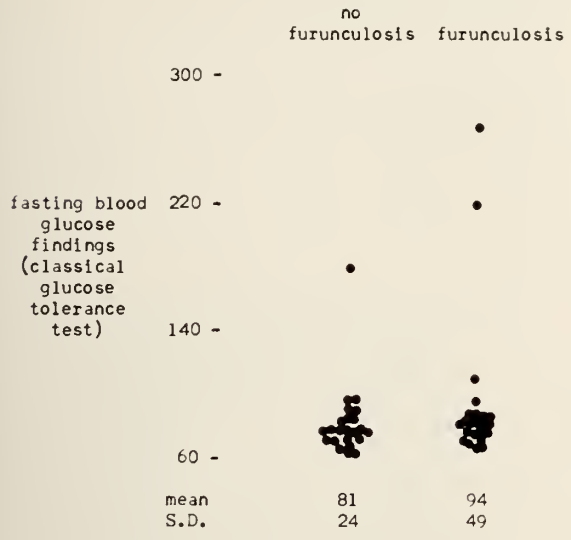


FIGURE 3

maining 170 (Group II) by means of the cortisone glucose tolerance technique.

2. All of the statistical analyses show that there were no statistically significant differences of the mean. However, an analysis of variance indicated that, at every temporal point, there was a statistically significant difference in variance in the Group I subjects.

3. A paired-group study was also done on the basis of age and sex similar to the analysis for the entire group. In the paired study, none of the differences of the means proved to be significant. However, all of the variances in Group I with one exception are statistically significant.

4. It appears that there is little significant relationship between furunculosis when one views the problem dichotomously (hyper- versus normoglycemia or diabetes mellitus versus no diabetes mellitus). However, if one views the data in a trichotomy (hyper-, normo-, and hypoglycemia), the results are different and more meaningful. In fact, there appears to be a distinct correlation between this particular finding and carbohydrate metabolism. More accurately, furunculosis seems to correlate with both relative hyper- and hypoglycemia.

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TREATMENT OF ALCOHOLISM*

Thomas T. Jones, M. D.

Durham, N. C.

Alcoholism is an ungrateful subject. Most of us here today are anything but open-minded or objective about it. The colossal dilemma for the alcoholic, those whom his life affects about him, and the community he fits and mis-fits, presents the urgency of "NOW" set in the continuum of individual and cultural perpetuation.

The alcoholic has his problem for his lifetime. The manner in which he handles it reveals the degree of his awareness of personal need, his honesty with himself, and his determination (or lack of it) to do something about it.

The Community has this complex cultural by-product, alcoholism, for the duration of its existence. The manner in which it handles this public health problem, the total problem, is a barometer of its social conscience, and its capacity to marshall its resources for practical and effective response.

The American Medical Association did, in 1956, by resolution passed by its House of Delegates, declare alcoholism to be a treatable disease, therefore—a medical responsibility.

Since treatment is a medical responsibility, met in general practice as well as in all specialties, it is well to take stock of the methods of treatment, and to judge application and results. But more than that, and for the essential purpose of this paper, I would presume to dwell on one special factor in therapeutic effectiveness.

That factor, that therapeutic factor, is the administrator of therapy—the doctor. But



before I present the case for him, may I speak of the essential elements in an illness or in any situation of medical concern; specifically, these elements are here applied to alcoholism.

These elements comprise the agent, the host, and the environment. In alcoholism, problem drinking or in crises that arise from an isolated minor or major drinking episode, the agent is any alcoholic beverage. Alcohol is (I feel we can all agree) an intoxicant, or substance capable of poisoning the organism ingesting it. The host, in our experience, is a human being who consumes the intoxicant. The environment may be social, diplomatic, fraternal, or connubial; it may be emotionally triggered by despair, joy, grief, anger, affection, loneliness or anxiety; it may have therapeutic overtones or ritualistic significance. Ball game or Ball, congeniality or hospitality, or just a drink for the drink's sake, in the act of drinking we acknowledge the place of alcoholic beverage in our culture, our sub-cultures, or in those circumstances that seem without rhyme or reason.

Thus, man drinks for some reason or apparent reason, clearly defined or obscure.

*Presented at the Second Annual Muscle Shoals Medical Assembly, August 8, 1964. Florence, Alabama.

Some drink too much, or without control, somewhere and under some conditions. A few become ill or suffer injury. In this area lies the responsibility of medicine. We judge the nature and degree of illness or injury, its impact on the concerned individual and on others involved; but we do not and we must not pass judgement on or condemn the patient. Our province is treatment—not condemnation.

Alcoholism is a disease. More than that it is a way of life for the individual so snarled in bottled bondage. Alcoholism is manifest in repeated, compulsive, excessive drinking in the individual whose dependence on alcoholic beverage has reached such a degree that he shows noticeable mental disturbance, obvious or hidden physical deterioration of functional and organic nature, interference with interpersonal relationships, and/or interference with social, domestic and economic function. Spiritual chaos most often completes the picture.

Regular, excessive drinking without apparent episodes of drunkenness or dys-social behaviour can and does cause myriads of departures from health, often unsuspected and/or ignored. Here there is additive microtrauma of even milder, repeated intoxication, which confronts us for honest appraisal and treatment even more often than the obvious alcoholic excess that characterizes the alcoholic. We see this daily, every doctor meets it. Do we consider it a valid symptom-complex or disease entity, and accept its justified claim on our concern? We should, for we are acquainted with many lesser illnesses that have major counterpart, and conscientiously treat them.

Now, back to that administrator of therapy —the doctor. You, and I. Do we qualify as the therapeutic monitor? Do we accept this role of therapist for the alcoholic or give lip-service only? Do we unreservedly go along with our professional responsibility to him without question or do we directly or (what is worse) indirectly deny him care?

As physicians, our course is clear. Alcoholism is a disease and the alcoholic a sick person. Alcoholics can be helped and are worth helping. This is a public health problem and therefore a public responsibility. Specifically in the twin areas of physical sickness and emotional distress his care is our responsibility. Who else is qualified, or given the right by law to treat the sick, and who else is as qualified to counsel in matters of behaviour disturbance or emotional conflict. (The minister admittedly is better prepared to serve as spiritual advisor, but he is so often seen much later in the progress of the illness, either in further deterioration, or somewhere along the upward course of rehabilitation. The doctor, again, as church member—or frequently as church officer—carries within him the personal dedication of spiritual ministry; and since such a role is part of his preparedness as a man made in the image of God, this ministry, if given free expression, is given the alcoholic as naturally as the persuasion of personality, or the rapport of faith.) Our basic qualifications, then, serve in the three areas of the alcoholic's greatest needs: physical healing, psychological or emotional stabilization, and spiritual comfort. Our potential has application that may result in improvement of man's regard for himself, better relationship with his fellowman, and increased faith in God. These elements are token and proof of competence in our professional service.

Next, if we assume the doctor is the most important factor in therapeutic effectiveness where the alcoholic is concerned, may these questions be asked with any justification? - - - Do we know just what alcoholism is? Do we know its protean and deceptive signs and symptoms? Do we know the mimicry it parades as other illnesses, or complications it causes to alter or disguise other illnesses? Do we know the defensive screen the alcoholic automatically erects to confuse or divert us into a less threatening relationship? Do we know our own professional compromise that causes us to blind ourselves to the inexorable erosion of alcoholism in our patient, as we eagerly and obediently follow his red herring of casual diversion to a diagnosis or explanation that has less threat to his ego, less stigma

to his self-appraisal, less chance in his eyes of hospital rejection or insurance denial?

Again, do we know, and know well, the measure of one alcoholic in the cross-section of our total community organization? Do we know the impact of the total number of alcoholics and equally disturbing excessive drinkers in this same community of ours. We've seen people drunk at games, cocktail parties, resorts, and miscellaneous celebrations. We've attended the injured who also were drunk. Our years as medical students and internes without doubt gave a liberal education with the symptoms and behaviour of the intoxicated patient in the emergency room. We saw him sick. We saw him hurt and bleeding. We saw him die. These situations were most certainly medical province and responsibility. But, have we also seen the alcoholic in court, in the pulpit, in a professional role, behind the wheel of a car? Have we attended A. A. meetings, talked with the inmates of jail, prison farm or penitentiary? Have we observed psychiatric counseling or visited a spiritual retreat for alcoholics, or a Half-way House?

Have we treated the alcoholic or just attended him during his brief days of drying-out? Or more specifically, have we treated him by all the cumulated and extended experience and substances of medicine at its best and most progressive, or have we mistreated him by denial and rejection or open hostility; by lip-service rather than effective, professional competence?

Not only are medical journals reflecting the increased interest in the alcoholic and excessive drinker, but most journals, professional and non-professional, radio and television, are finding room for articles dealing with this problem. Scanning the newspapers of any week would give a wide choice of topics for any conceivable subject-matter of interest for information or research.

A visit to an A. A. meeting is a revelation; many visits easily would constitute a liberal education in basic, simplified psychotherapy. It costs nothing but time.

But if we really want to experience a profitable interneship in this area of concern, spend a day in magistrate's court, listen to social service interviews with welfare applicants, become familiar with unemployment problems, industrial attitudes, professional grievance committees. And more, attend an A. A. meeting at a prison, share the fellowship of coffee, cakes and conversation, and learn by heart and with your heart the destructiveness of hate, the healing quality of love, and the stark loneliness of every alcoholic that is revealed in the agonized, consistent and repeated protests that at once and for all give you cause, analysis, appraisal and summation of this problem, and as well—or better—give solid clues to the needs, which, fulfilled, may lead to conversion and rehabilitation of the alcoholic.

These generalities have behind them a prodigious literature of ways and means a doctor can improve his role, his therapeutic effectiveness, his professional competence in stewardship and ministry of service to the individual alcoholic, his immediate family and his community.

The medical role is considerable. We can assume and guide it. If community resources are organized, we can give them our support. Continuity of care is never abdicated. We are key tools of therapy—and specific medical tools are ours and ours only to administer.

Our intelligence, our professional competence is not questioned; it is our hearts that are challenged. Our hearts' response towards the alcoholic is the real measure of our right to treat him.

In summary, attitude of acceptance; the intimate, rugged, honest interneship in the areas where alcoholics seek help and endure penalty; the acknowledgement of the enormity of this problem as a cultural by-product; the understanding of the needs of the individual alcoholic; and the willingness to give him our professional skill with insight to help him find and pursue the steps he himself should take; these qualifications characterize the most potent agent in the treatment of alcoholism—the family doctor.



Editorial COMMENT

CHRISTMAS is with us again, as it has been year after year for centuries, bearing witness that there is an endless continuity and a reassuring certainty still triumphant over all the uncertainties of life. We in the Medical Association of the State of Alabama wish you a full measure of peace, good will, and hope betokened by the Season.

Whatever the future betides, America has an impregnable bulwark of resources to provide against the uncertainties that may befall us. Members of the Medical Association of the State of Alabama, for instance, lend their own distinctive aura of certainty to this Christmas season with a record of 104 years of devotion to the protection of health and life.

With the advent of another New Year for all of us, we wish you happiness and good fortune.

WHO SPEAKS FOR ALABAMA MEDICINE?

Alabama medicine will come to many crossroads in the days ahead, both at national and state legislative levels. Many bills will be introduced, in Washington and in Montgomery, which will have far-reaching effects on this profession.

Whose voice, knowledgeable and authoritative, will speak for the health of the people of Alabama?

At present there are five doctors in the Georgia House of Representatives. These men, most likely serving at a tremendous financial sacrifice, will constitute a formidable bulwark against hasty and ill-conceived legislation. Such a bloc, serving on key committees, will have first-hand information on proposed laws. And it is safe to assume that they will move rapidly to amend or kill any legislation deemed injurious to the public welfare. Their voices are ever-present—to warn, to counsel, to protest if need be—and their stature as lawmakers makes it possible to appeal directly to the people when legislative actions constitute a danger.

Here in Alabama there is no single legislator with a vested interest in the health of this state. This is not to say that no legislator is concerned in this matter; and a majority of our senators and representatives have proven, over the years, to be sympathetic to the cause of public health.

But it is equally true that practically every other organized group—educators, bankers, labor—have strong and direct voices in the legislature; and their influence has been effective in passing or rejecting legislation peculiar to their interests.

The doctors of Alabama, working in concert with paramedical groups, can afford to do no less.

It is too late now for medicine to sound its own voice in the 1965 Legislature. Once again we must lean on our staunch friends to fight our battles. But 1966 is another matter, and when the time comes to qualify for public office, let us hope that doctors throughout Alabama will rise to the challenge and compete for seats in the Legislature.

Let medicine's voice be heard, loud and clear! If the doctors of our state are to completely fulfill their obligations to humanity, let them now come down out of the galleries and take their places among the lawmakers.

MEDICAL SCHOOLS ENROLLMENT IS 1,026

The University of Alabama Medical Center began its academic year with a total of 840 students enrolled in its various schools related to the health sciences.

In addition to the actual students matriculated at the Medical Center, 46 interns and 140 residents are receiving advanced training, making a complete total of 1,026.

The Medical College of Alabama, with 80 freshmen, will have approximately 300 students in training to become physicians.

The School of Dentistry, with 52 freshmen, has a total of 191 students.

University Hospital's School of Nursing has 76 new student nurses, making a total of 195 nurses in training. The remaining paramedical schools, including schools of Anesthesia for Nurses, Radiological Technology, Medical Technology, Blood Bank Technology, Laboratory Assistance, Cytotechnology, Dietetic Internships, Hospital Administration Internships, Social Service Internships and Physical Therapy, are instructing another 68 students.

The Medical Center graduate program has 56 enrollees who are candidates for degrees and 32 postgraduate students who are working toward certificates.

President's Page



Since political analysis is the order of the day and will be for some time to come, there is no reason why it should not be attempted by the writer.

This is an era of "trends." To be able to spot a trend and judge it correctly is making use of that sixth sense, or intuition, that spells success. Those of us who had felt the trend in this state since the recent campaign began had no need to appear over-confident about the outcome. Visiting other parts of the nation, particularly the East, indicated that the conservative forces were having a difficult time.

Our own fight to stop the medicare legislation in Congress was only part of the picture. The passage of the Civil Rights Law, the Appalachia Project, and the other so-called liberal measures, indicated that conservative thinking did not have enough votes.

All the leaders in Congress have denied since the election that John F. Kennedy's death hastened the passage of this type of legislation. They all felt that it was ready to be passed, and Mr. Johnson's "masterful manipulation" helped put it across. The fact that the five "deep-South" states voted against this legislation and against him makes any conjecture as to the future of this region quite serious.

Medicare legislation does not have to be passed as it was written in the original King-Anderson Bill and later modified by Senator Gore of Tennessee.

Kerr-Mills can still be utilized if enough funds are provided. The AMA will need to co-ordinate the propaganda for Kerr-Mills and not stimulate the people just to seek information from the local medical profession in the various communities. The people must be instructed to see their Congressmen.

It is said that it will take $2 billion to implement Kerr-Mills properly from existing taxes. On the other hand, the additional payroll tax to provide the benefits under Social Security will ruin the Social Security system and only provide for those who are eligible for the social security benefits over age 65.

This government will never be able to finance total medical care for the entire population without bankrupting itself. Even in the Scandinavian countries such as Sweden where so-called total care is provided, there is an indemnity plan that must be followed to obtain this care.

Whether this State or the Deep South stay in the Republican column remains to be seen. Nevertheless, the conservative viewpoint remains uppermost in this region, and we can operate with the "strong loyal minority."

We have lost some important committee assignments in the House by electing Republican Representatives; but, if the new Congressmen from this State are as dedicated to the conservative cause as they have proclaimed in their campaign speeches, then Medicine has a group of new champions; and the two party system may certainly be here to stay.

E. B. Glenn, M. D.

The Month In Washington

From the Washington Office
American Medical Association

The Johnson Administration has placed so-called medicare at the top of its legislative program for 1965.

In a policy paper issued a few days before the national elections, President Johnson said:

"First we must provide adequate hospital and nursing home care for our senior citizens by a sound program financed through contributory social insurance. I pledge that the legislation to accomplish this will head my program next year."

Administration forces in Congress expressed confidence that most of Johnson's legislative program would be approved next year in light of the Democratic victory in the elections. Democrats gained a net of 37 seats in the House.

The Administration was reported to be considering a program that would be financed by a separate employer-employee tax rather than an increase in the social security tax as called for in legislation that died in a House-Senate conference committee when Congress adjourned in October.

In reiterating his opposition to Social Security financing, Rep. Wilbur D. Mills (D., Ark.), chairman of the Ways and Means Committee, said just prior to adjournment:

"I think one of the difficulties that has actually impeded the reaching of a sound solution is the insistence by the proponents of medical care on proceeding toward a solution through the existing OASDI (Social Security) system rather than in an all-out effort to solve the problem itself with some flexibility in their approach. In other words, there may well be within our reach solutions to the admittedly difficult and increasing problems of medical care for the aged which lie outside of attaching a Federal program to the framework of the OASDI insurance system . . .

"I would be hopeful that the basic prepayment concept might lead us in the direction of sound approaches to this matter. There are other principles which we can embody to insure a sound medical program while at the same time preserving our basic social security insurance system."

Other points listed in Johnson's policy paper on health were:

"Second, we must step up the fight on mental health and mental retardation.

"I intend to ask for increased funds for research centers, for special teacher training, and for helping coordinated state and local programs.

"Third, we must expand our program to help train the doctors, dentists and technicians this nation desperately needs. Right now, the statistics show that we are importing interns and resident physicians from other countries which can ill afford to lose them.

"Fourth, we must enlarge programs to help disabled citizens rehabilitate themselves for useful employment.

"Fifth, we must increase existing programs of medical assistance to children of low-income families.

"Sixth, we must work to correct the deficiencies of young men who are rejected for military service because of health.

"Seventh, we must move ahead in the effort to protect the purity of the water we drink and the air we breathe. Air pollution, according to one estimate, causes $11 billion damage each year to property alone. No one can measure the damage to our children's lungs."

* * *

A total of $35 million in Federal funds has been appropriated to help finance construction of community mental health centers in 1965.

It is the initial allotment of funds for a $150 million three-year program of Federal

grants-in-aid for building such centers. Grants will range from one-third to two-thirds of total construction costs.

The Department of Health, Education and Welfare said the centers built in 1965 will form the nucleus of the new national mental health program to provide comprehensive treatment of the mentally ill in the patients' home communities.

Grants will be administered and awarded to eligible sponsors of the centers by the National Institute of Mental Health of the Public Health Service under terms of the Community Mental Health Centers Construction Act of 1963 (Public Law 88-164).

The centers must provide a minimum of the following five essential services to patients: inpatient treatment, outpatient treatment, partial hospitalization, with around-the-clock emergency service available in at least one of these. Centers must also provide consultation and educational services to community agencies.

In addition to the construction funds for centers, NIMH will grant $12 million in 1965 to hospitals for the mentally ill and for the mentally retarded to improve treatment and care of patients.

NIMH also will award $6 million in inservice training grants during 1965 to upgrade skills of hospital personnel in providing comprehensive care for patients.

Other funds available to NIMH under the regular mental health appropriation of 1965 include $163.7 million for research, fellowships, training of professionals and State grants, and $24.2 million for Institute research and items of direct operations.

* * *

About two of every 15 American adults have definite heart disease and an additional one of nine have suspect heart disease, according to the Public Health Services National Heart Survey.

The survey comprised a sampling of 7,710 adults with 6,672 given physical examinations from 1959 through 1962. Major projected findings included:

—Of the 111.1 million American adults, 14.6 million have definite heart disease and 13 million have suspect heart disease. Of every 100 persons aged 18 through 79, 13.2 had definite heart disease and an additional 11.7 had suspect heart disease.

—Most commonly encountered was hypertensive heart disease. More than 10 million Americans suffer from it, and nearly 4.8 million others have suspect hypertension.

—Coronary heart disease accounts for 3.1 million definite and 2.4 million suspect cases.

—Women are more likely to have definite hypertensive heart disease; men more likely to have definite coronary heart disease or heart disease of congenital or syphilitic origin. Suspect hypertensive heart disease is more common in men than in women; suspect coronary disease more common in women than in men.

—About 24.4 per cent of negro adults have definite heart disease, twice as high as the incidence for white adults.

—The prevalence rates for suspect heart disease are 14.8 and 11.3 per cent, respectively, for negroes and white.

—The prevalence of heart disease rises sharply with age. Less than two per cent had definite heart disease in the 18-24 age group.

—About 39 per cent of the men and 46 per cent of the women in the 75-79 age group have definite heart disease.

SPECIAL NOTICE

Beginning in 1965 NEW APPLICANTS will be required to submit an application for the Part I (written) examination (together with training verifications) between January 1st and February 28th. Previous applicants (Reopened and Re-examinees), whose training credits have been approved by the Credentials Committee of this Board, may be scheduled for the Part I examination upon written request received no later than February 28th in the year of examination.



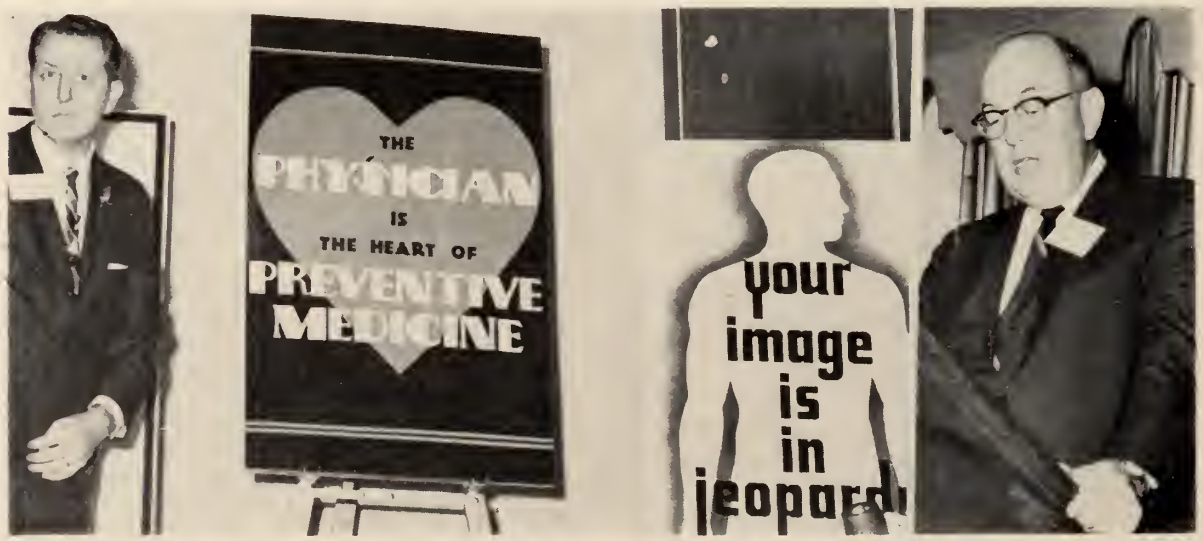
IT'S A MATTER OF FACT

Dr. Myers Cites Failure To Support Public Health

The state of the State's health might well have been the topic of an impassioned plea for additional funds made at a called meeting of officers, counsellors and delegates of the Medical Association of the State of Alabama by Dr. Ira L. Myers, State Health Officer, on Sunday, November 1.

Calling for an increased appropriation of at least $2 million, Dr. Myers graphically described the low state to which Public Health services in Alabama have fallen due to lack of operating funds, insufficient personnel, and inadequate salaries.

Following are excerpts from Dr. Myers' speech which brought forth a resolution, unanimously adopted, placing the Association



Dr. Ira L. Myers (left) Discusses Public Health Situation; President-elect Dr. J. G. Donald Offers Resolution of Relief.





Dr. L. L. Hill Registers With Mrs. Mary Nell Williford; (Right) Dr. J. Paul Jones Chats With Dr. and Mrs. C. W. Neville.

squarely behind him in an effort to relieve the situation:

* * *

The physician is the heart of preventive medicine. This fact was paramount in the minds of the founding fathers of this Association and its inseparable organization as a State Board of Health. From its inception in 1875, eighty-nine years ago, physicians involved in the private practice of curative medicine were also concerned and charged with a unique responsibility for Public Health as well.

Many of us, or so it appears to me, have never fully appreciated that we are privileged to exercise control over the entire practice of medicine, both governmental and private, in a way which can be claimed by no one else anywhere. We are the last stronghold of this interwoven concern for the entire health of our people both as individual patients and the public as a community or body politic. In 1937 Alabama became the first state in the nation to have full-time county health departments in every county.

As a county medical society, you elect a Board of Health and you elect a County Health Officer. You charge him with responsibilities or you permit him to shirk his duties; and, eventually, if he should be noted to be negligent, you alone can stimulate him **directly** to improve, or release him from employment.

These are actions the State has delegated to you as a County Society and I cannot hire you a competent health officer or relieve you of an unsuccessful or incompetent or inactive one. It appears we both may have been negligent in our duties on occasion.





Dr. William B. Virgin Makes Legislative Report; Listening (Left to Right) Dr. S. J. Campbell, Vice President, Dr. E. B. Glenn, President, Dr. W. L. Smith, Secretary, and Drs. H. E. Askins, E. L. Strandell and G. H. Stokes, Vice Presidents.



Dr. R. M. Miller, Jr., Introduces Luncheon Speakers, House Speaker Albert Brewer (Center) and Congressman-Elect James Martin.

Alabama once led the nation in Public Health and preventive medicine. It now faces professional bankruptcy and both medical and political nutritional anemia. It has become crystal clear that it is just as impossible to run a specialized preventive medical program without proper medical direction as it would be foolhardy to attempt to operate an active hospital without doctors and nurses.

The termites of decay have attacked our organizational structure. These signs of internal decay began to appear with the gradual loss of trained physicians without permanent replacement. During the depression years, physician services were cheap and many good physicians entered Public Health. Consequently, Public Health services flourished, but times changed and some left to go to greener fields while others were called into military service in World War II. Acting health officers were illegally utilized to fill this gap temporarily. In several cases this condition persisted too long, and these men who served in an emergency found the demands of patients in their private practice more urgent than the vague goals and intangibles of prevention.

Consequently, local direct health services to people suffered and became weak where health promotion should be strongest—at the local level. These needs were poorly understood and the legislators observed these defects at home and, naturally, were reluctant to adequately support programs with little tangible results from the dollars appropriated.

The pleas of the state health officer, and a few of the Committee of Public Health, for increased funds found a minimum of response. All the state costs of government were increasing and active demands from the public for improvements in education, highways, and welfare payments for the indigent and aged were the more prominent.

With the exception of tuberculosis treatment, which has been actively supported by the District Sanatorium Boards and the Alabama Tuberculosis Association, state supported health services have diminished in several areas and have been diluted with new demands and faced with new problems which had no financial support or were inadequately funded.

To be outside the realm of political influence may be desirable to avoid interference in a scientific and medical program, but it also may leave us devoid of positive financial support and interest without which we fade into obscurity rather than rise to usefulness.

The increasing demands for updating



Two Segments Of The Approximately 350 Participants In Called Meeting To Discuss Public Health Matters.

health services were not clearly understood by the legislature and were ignored by the public. Repeatedly, public health officials have been commended for their dedication and progress and lack of epidemics and were urged to continue their good work. To most, this was conservative government; but the small increases in appropriations failed to keep pace with the changes in the costs of living. County governments were encouraged to increase their share of the finances for health services.

In desperation we have nursed at the breast of the Federal government for financial nutrition to meet urgent basic program needs which were being actively promoted and fostered at the national level. These needs were given priority over problems generally recognized by the state. This milk we received has soured in our mouths as this temporary support ended as a demonstration without local support and the Federal funds shifted to a new area of interest which appealed to Congress.

This has proven disastrous because instead of planning to meet the needs of our area, we have succumbed to the temptation of accepting a Federal grant and abiding by its specific restrictions to perform a function which in many cases was good, but not of paramount priority in terms of the needs of Alabama's citizens.



At Breakfast Before Meeting: Dr. H. E. Gray and Dr. J. G. Daves, Past Presidents (Left) and Dr. and Mrs. J. M. Chenault.

This trend led to the second dilemma. In an effort to get this "easy money" we were required to show our interest and good faith by matching the Federal dollars with state and local funds. To do this we have gradually depleted our basic operating funds in the desperate effort to double our money or get our share of the Federal money to, at least, meet some of the increasing needs which were urgent or pressing.

* * *

We no longer have a director of public health nursing, a basic and essential component of health service. We have only 21 local health officers attempting to serve 67 counties with grossly inadequate supporting staffs. Within four years 62% of these reach age 65, the age of voluntary retirement (compulsory retirement is age 70).

Even at best, within five years the present state health officer would be the only physician in the State Health Department under the age of 65.

* * *

As a direct result of these conditions, a psychiatrist could not be employed to direct the mental hygiene program and now the Board faces the decapitation of public health by removal of mental health from the control of the Board of Health and giving it to another group to be yet determined.

* * *

Physician time is now so limited in the State Health Department that illness or vacations by any physician leaves the entire organization in jeopardy, and any prolonged shortage of service of one or more physicians would be disastrous. There is no flexibility and no one in training with time running out fast.

Our chronic illness program is coasting without direct physician direction. An immunization program is being studied and promoted primarily by trained laymen. Health administrators are being tried in three counties.

We have no biostatistician to help pinpoint out problems, and we face an acute shortage of sanitary engineers in the next three to five years.

We have no active medical field epidemiologist and can offer almost no assistance to county health officers and physicians.

We have no one to work on the increasing problems of narcotic violations and drug misuse which is a legal responsibility of the Board.

We have no veterinarian for meat inspection and food sanitation consultation, nor have we been able to recruit an assistant to the state health officer as an understudy.

Already there are those at the door who are anxious to offer direction and active support to various segments of public health which has suffered by default of interest of the majority of the physicians of this state who are the members of the State Board of Health.

I am reminded that it's inappropriate to be critical of the corpse while serving as a pallbearer. Public Health may be fat with an income of over $15 million per annum, but is presently in a state of profound professional shock and the point of reversible change may be already past.

In the absence of trained professional personnel there is too little planning and no vision. Without planning one is dependent on chance which is a risk unwarranted. Unless there is vision there can be no effective planning and "the people perish."



WESTCHESTER (N. Y.) MEDICAL BULLETIN



around the state

ABOARD HOSPITAL SHIP 'HOPE'

ALABAMA DOCTORS SERVE IN ECUADOR



The teaching-training hospital ship S. S. HOPE enters the port city of Guayaquil, Ecuador to begin a ten-month medical mission.

W. A. Daniel, Jr., M. D.
D. S. Hagood, M. D.
H. J. Till, M. D.

Montgomery, Alabama

This year we three physicians had the privilege of serving on the hospital ship HOPE in Ecuador. The HOPE Project is truly a people-to-people project in that it is supported by the donations of the people in the United States, and various pharmaceutical companies and not by our government.

The ship remains in the host country almost a year and provides not only care of patients but teaching of nurses, technicians, and doctors of that country.

Other than five permanent physicians, about thirty doctors rotate each two months to give their services free in this program.

Each physician has a counterpart who has given up his practice for a month to work with the United States physician learning our methods and opinions. He in turn often teaches the visiting physician, but the greatest value is the formation of friendships between doctors of different countries.

In pediatrics during August there were three phases of work. First came care of patients aboard ship who had been selected from shore-based clinics.

At this period most patients were surgical, but the pediatricians provided pre- and post-operative care for a wide variety of infants and children.

A second phase was working in the clinics, and many patients were seen there. Malnutrition, diarrhea and intestinal parasites were the most common conditions. There was also a significant number of children with aplastic anemia due to the availability of drugs with no prescription required.

Patients from these barrio (slum) clinics were selected for ship care and teaching of interns and residents aboard ship. Rounds were also made on the wards of local hospitals.

A great lack of technical skill was apparent, and little or no bacteriology was available. No electrolyte studies could be obtained, so often these were done on the ship.

With Ecuador having the world's highest rate of population growth, it is no wonder that children were everywhere and form the greatest area of medical need. Officially two of every five children die before the age of five years from malnutrition or preventable diseases. This led to the third phase of the pediatric program; and, with the help of the Ecuadorian government, an immunization program for diphtheria, tetanus, whooping cough, polio and smallpox was initiated.

It is of interest that almost everyone in Ecuador is now protected from smallpox except the Aucas and two other jungle tribes who were not impressed by the program but did, with blow guns and curare-tipped arrows, impress those who went to vaccinate them.

All babies are breast fed until the milk becomes inadequate, then malnutrition sets in. Protein deficiency is the rule, and tuberculosis usually comes along to add its effects even in very young infants.

Thus HOPE organized a nutritional education program with the help of Ecuadorian women volunteers and members of our Peace Corps—and let us here give a salute to the young men and women of that organization.

Ophthalmic diseases are very high in Ecuador, and the eye service was one of the busiest aboard ship with two days a week set aside for surgery and four mornings spent in local hospitals. Corneal disease with severe scarring was extremely high in incidence.



Ecuador's Children Form Greatest Area Of Medical Need.

It begins in infancy when the child has diarrhea—and, with dehydration, becomes stuporous or comatose with the eyes open for long periods of time with concomitant drying of the cornea and the development of ulcers.

As would be expected, there are many pterygiums in Ecuador as there are almost 12 hours of sunshine with extremely high ultraviolet content every day. After removal of the pterygiums, 85-90% will recur unless Beta radiation is used following the surgery.

No acute glaucoma was seen in two months, and less chronic glaucoma was seen than in Alabama.

Cataracts are very common, and it was interesting that one specific area of the country had an extremely high incidence. Most of these were of the senile type. Several cases of detached retina were seen.

The usual types of squint, cases of disfigurement from old osteomyelitis, and the

usual things we see at home were common; but the cases we saw were usually longer standing and often more extreme.

The patients were, in general, more stoic and resigned to suffering than is observed in the average ophthalmological practice in our own country; and, it may also be added that the patients seemed more grateful!

Of necessity, the hospital stay was far shorter than here. As a matter of fact, some of the cataract extractions were done on an out-patient basis, and not a single patient developed complications as the result of such treatment.

This two months service was a most rewarding and satisfying experience and certainly teaches one to be more appreciative of the advantages we have at home—advantages we more often than not take for granted.

On the ship all surgical specialties were represented by doctors from the United States, and a good many of the surgeons had university connections but were not necessarily on the faculty.

There were three operating rooms available, and the instruments were adequate for most types of surgery. Monitoring devices were available; x-ray equipment was new and excellent, including X-Omat film processors.

The nurses and technicians had been well-selected and were competent. Morale in the operating room was excellent; and the rooms were always filled with Ecuadorian surgeons, residents and interns.

There were many of these trainees and counterparts eager to see and learn, and usually about 10 Ecuadorians scrubbed and observed the operations.

Anesthesia was excellent with an M. D. anesthesiologist and four good nurse anesthetists. This group was also training Ecuadorian nurses and doctors in anesthesia, for trained anesthesiologists are rare in Ecuador.

Competent pathology for frozen sections was available.

During August, 180 operations were done aboard: eye, plastic, urology, orthopedic, dental, neurological, gynecological and general surgery. Only open heart surgery was omitted.

The recipients of these operations were charity patients of special teaching interest. These patients and their families and friends were very grateful, and will have lasting good will for the U. S. doctors and nurses aboard the HOPE.

Obtaining blood for transfusions was at first a difficult problem, and many times surgery had to be delayed. However, eventually the people learned that they would not be harmed by giving blood and donated it more willingly.

Once again we were all impressed by the complete faith and trust the people had in us; they eagerly submitted to the recommended operations, and this is due in large part to the good will and faith created by preceding surgeons on the ship.



Two Out Of Five Die Before They Reach Five Years Of Age.

The second month Dr. Till was stationed in Cuenca, a small town in the mountains. There this doctor, an anesthesiologist and surgical nurse, worked and operated at the medical school. Due to lack of funds, many instruments and machines were lacking—but progress is being made. Surgery was done in the mornings and teaching rounds made with interns and residents.

After the usual siesta from 1 to 3 P. M., lectures were given to students, interns and residents. Here infection was the most common cause of death, with malignancies of all types being next. There was very little arteriosclerosis. Volvulus of small and large bowel was common and probably due to the bolus or bezoar effect of the high carbohydrate, corn diet and the ever-present intestinal parasites. Intestinal fistulae were common.

In the ten months that the ship was in Ecuador it was impossible to operate upon or treat all of the people who needed treatment. However, the poor people quickly learned about the HOPE; and many, many thousands received an intimate relationship and good image of United States doctors, nurses and medical care. It is to be hoped that these relationships will be lasting.

Much could be written about Ecuador the country, its people and hundreds of most interesting incidents which occurred. Also what the HOPE project does to the doctor who serves could be another chapter; but, let us say that we came to love Ecuador and its people.



Ecuadorians Were Eager To Learn Modern Techniques.

We have some lasting friendships with medical colleagues; and, although we believe we worked hard, we admit we have received much more than we have given. And, we hope we can do it again!

AMA Research Institute To Open July 1, 1965

The Biomedical Research Institute of the American Medical Association Education and Research Foundation will open July 1, 1965, AMA-ERF Board President Raymond M. McKeown, M. D., Coos Bay, Oregon, announces.

Headquarters for the institute will be located in a new addition to the AMA headquarters building. The project, now under construction, will include about 30,000 square feet of laboratory space.

American Academy of Physical Medicine and Rehabilitation

The annual meeting of the American Academy of Physical Medicine and Rehabilitation will be held on August 22-27, 1965, at the Sheraton Hotel, in Philadelphia. It will consist of formal lectures, as well as educational seminars in the field of Hypertonia, Hypotonia, and Forensic Physiatry (Workmen's Compensation).

"REPRIEVE"

Heart Disease Control Program 16 MM Film

General Dwight D. Eisenhower tells how sensible living habits and adherence to doctors' orders have enabled him to recover from a heart attack in a 16-millimeter color motion picture, called "Reprieve," sponsored by the Heart Disease Control Program of the Public Health Service, U. S. Department of Health, Education, and Welfare.

Other heart patients who tell their stories through this film include a farmer, a mechanic, and a banker—all from Salisbury, a fishing and farming community on the Eastern Shore of Maryland.

Executive producer and narrator of the film is Dr. Murdock Head, Director of the Airlie Foundation. This film is now available for public showing through the Public Health Service, Audiovisual Facility, Atlanta, Georgia 30333.

Clinical Center Study Of Carotid Body Tumors

The co-operation of physicians is requested in the referral of patients with carotid body tumors for a study at the Clinical Center being conducted by the National Institute of Arthritis and Metabolic Diseases and the National Heart Institute. Purpose of the study is to relate histochemical evidence of catecholamine containing cells in carotid body tissue to excretion of catecholamines and their metabolites.

Patients admitted to this study will be evaluated for definitive treatment. Upon completion of their study, patients will be returned to the care of their referring physicians who will receive a complete narrative summary and report of findings.

Physicians interested in having their patients considered for admission to this study may write or telephone: George G. Glenner, M. D., Clinical Center, Room 3-N-112, National Institutes of Health, Bethesda, Maryland 20014.

New Orleans Graduate Medical Assembly Meets March 8-11

The twenty-eighth meeting of the New Orleans Graduate Medical Assembly will be held March 8-11, 1965 at the Roosevelt Hotel.

Nineteen outstanding guest speakers will participate, and their presentations will be of interest to both specialists and general practitioners.

Dr. Paul Dudley White Delivers Harrison Lecture

An illustrious figure in cardiology, Dr. Paul Dudley White, came to Birmingham November 17 to deliver the Seventh Annual Tinsley Randolph Harrison Lecture, presented by the University of Alabama Medical Center.

The lecture was established in honor of Dr. Harrison in 1958 by the Medical Center, and each year an outstanding man of medicine is invited to deliver it.

Dr. White, clinical professor emeritus of Harvard Medical School, is renowned as one of the pioneers and leaders of study and treatment of heart disease.

* * *

Dr. Champ Lyons Given Faculty Lecturer Award

Dr. Champ Lyons, professor and chairman, Department of Surgery, chief of surgical services and co-chief of staff, University of Alabama Medical Center, has been selected as recipient of the University of Alabama Medical Center's Distinguished Faculty Lecturer Award. Announcement came from Dr. Joseph F. Volker, vice president for health affairs.

The award is given in recognition of the accomplishments of Medical Center faculty members, evidenced by the advancement of the frontiers of health and science, and for outstanding contributions to the University of Alabama Medical Center through education, research or public service. The recipient of the award presents a lecture to the faculty and friends of the Medical Center during the spring semester.

Course In Laryngology and Bronchoesophagology

The Department of Otolaryngology, College of Medicine of the University of Illinois at the Medical Center, Chicago, will conduct a postgraduate course in Laryngology and Brochoesophagology from March 29 through April 10, 1965. This course, limited to fifteen physicians, will be under the direction of Paul H. Holinger, M. D., and will be held at the new Illinois Eye and Ear Infirmary, 1855 West Taylor Street, Chicago. Instruction will be provided by means of animal demonstrations, and practice in brochoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Interested registrants will please write directly to the Department of Otolaryngology, College of Medicine of the University of Illinois at the Medical Center, 1853 West Polk Street, Chicago, Illinois 60612.



"First promise you won't scold!"

Westchester (N. Y.) Medical Bulletin

ANNOUNCING

THE TWENTY-EIGHTH ANNUAL MEETING

OF

THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

Conference Headquarters—Roosevelt Hotel

MARCH 8, 9, 10, 11, 1965

GUEST SPEAKERS

James E. Eckenhoff, M. D., Philadelphia, Pa.
Anesthesiology
A. W. Martin Marino, Jr., M. D., Brooklyn, N. Y.
Colon and Rectal Surgery
Wiley Mitchell Sams, M. D., Miami, Fla.
Dermatology
Maurice L. Kelley, Jr., M. D., Rochester, N. Y.
Gastroenterology
Robert I. Wise, M. D., Philadelphia, Pa.
General Practice
Curtis J. Lund, M. D., Rochester, N. Y.
Gynecology
S. Gilbert Blount, M. D., Denver, Colo.
Internal Medicine
Jerome W. Conn, M. D., Ann Arbor, Mich.
Internal Medicine
Francis Murphey, M. D., Memphis, Tenn.
Neurologic Surgery
Bayard Carter, M. D., Durham, N. C.
Obstetrics
William F. Hughes, M. D., Chicago, Ill.
Ophthalmology
Milton S. Thompson, M. D., San Antonio, Tex.
Orthopedic Surgery
Benjamin Castleman, M. D., Boston, Mass.
Pathology
Harry C. Shirkey, M. D., Birmingham, Ala.
Pediatrics
Richard H. Marshak, M. D., New York, N. Y.
Radiology
Warren H. Cole, M. D., Chicago, Ill.
Surgery
Preston A. Wade, M. D., New York, N. Y.
Surgery
Robert Lich, Jr., M. D., Louisville, Ky.
Urology

ADDITIONAL SPEAKER TO BE ANNOUNCED

Lectures, symposia, clinicopathologic conferences, round-table luncheons, medical motion pictures, technical exhibits and entertainment for visiting wives.

Acceptable for twenty-nine accredited hours by the American Academy of General Practice.

(All-inclusive registration fee—$25.00)

For information concerning the Assembly meeting write Secretary, The New Orleans Graduate Medical Assembly, Room 1528, 1430 Tulane Avenue, New Orleans, La. 70112

About 200,000 persons a year try

SUICIDE FOR SURCEASE

but only create trouble for society and insurance.

DOCTORS RENDERED a dread diagnosis after exploratory surgery: The patient had peritoneal carcinomatosis, a medical way of saying terminal cancer that might permit the man months or perhaps several years of life. Knowledge of the medical verdict sent the middle-aged cancer victim into a sea of depression that found him lamenting his fate on nightly walks through city streets. After three years of abysmal despair the patient was the subject of an auto accident report. He walked into the side of a passing car at 3 a.m., an hour when streets are empty and the city is blind to one's darkest intentions.

Was his death accidental or was it suicide, a deliberate act of self-destruction contrived to provide a liability insurance settlement for a widow who had already suffered too long?

This dismal episode, uncovered and analyzed by Harvard University medicolegal researchers, characterizes the personal and social dilemma of suicide, a psychic problem that ranks in severity with our most dread physical diseases. Suicide officially ranks 11th among causes of death, though it is often not reported or ignored as a possible death cause. Each year an estimated 26,000 persons succeed in killing themselves, and another 180,000 attempt it. More than 2 million living Americans have tried suicide at least once. And rates of officially successful suicides vary from 10.9 per 100,000 population nationally to 8 in New York City, 16 in Los Angeles County and 28.6 in San Francisco.

Suicide rates, however, are highly deceptive since they are based on official reports, often disguised for reasons of religious conviction or compassion for the deceased's family. Operators of a suicide prevention center in Los Angeles estimate that fully 50 per cent of suicides are not truthfully reported. In some areas autopsies are performed in fewer than 10 per cent of all deaths, and advanced medicolegal investigative techniques are just now coming into use in fixing causes of death in urban areas.

Slipshod reporting and outright coverups of suicides not only hamper efforts at suicide prevention, but create one serious aspect of the insurance problem involved in instances of self-destruction. Insurance, designed to protect the value of life and property against



unforeseen hazards, is unfairly challenged by those who involve other persons and property in their self-destructive schemes. Suicide, masquerading as accidental death, may subject innocent parties to liability claims, as illustrated by the pedestrian-victim with terminal cancer. Refusal of officials to thoroughly investigate and report suicides adds to the possibility that such unwarranted claims will be honored.

Dramatic cases in point are those involving two forms of suicide by auto: those in which pedestrians purposely walk into death paths, and those in which motorists purposely crash their vehicles in hope of accomplishing sui-

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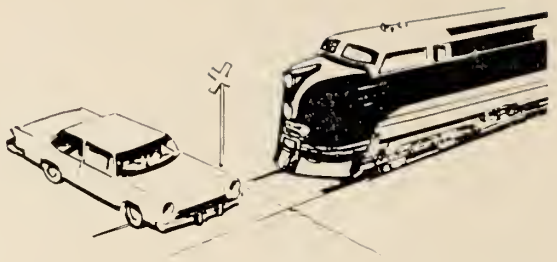
(From Journal of American Insurance. Vol. 40, No. 10)

cide. In the first case, the pedestrian may leave a lucrative liability claim for his survivors, and possibly a large settlement under double indemnity provisions of life insurance policies providing for larger settlements for accidental death. Moreover, such suicide techniques avert embarrassment for survivors since they are reported as "accidents." Not incidentally, suicides who destroy themselves in the paths of vehicles jeopardize the driving privileges and psychological well-being of innocent drivers. Similar consequences for society stem from the twisted designs of those who purposely drive to their deaths. Many such suicides maim or kill innocent victims as well as themselves.

Suicide can also be costly for workmen's compensation insurers. In one such case a truck driver became depressed and developed a psychosis after striking a pedestrian. He later committed suicide, and his family collected a workmen's compensation insurance death benefit.

Payment of a death benefit to the truck driver's family exemplifies the connection between the act of suicide and workmen's compensation insurance. Generally there is a presumption against suicide. That is, if a worker is found dead in an elevator shaft or beneath a stone crusher, he is presumed to have died accidentally unless a suicide note or some other incontrovertible evidence is found. In some jurisdictions it is sufficient for recovery of benefits to find that a worker's injury is related to mental suffering that caused him to commit suicide. When a worker-suicide injures or kills his colleagues, payment of workmen's compensation to his victims or their survivors would depend upon the jurisdiction. Some states hold that the employer has no control over such events, and is therefore not liable. Others grant recovery.

Mutual property insurance companies take a general "soft" view of suicides in that they believe few suicides will destroy their own property in order to gain an insurance settlement. A mutual company, for example, recently paid in full a claim on contents and personal effects in a New York apartment



that was exploded when a woman opened gas jets and allowed natural gas to escape until it reached pilot lights, blowing the apartment to smithereens. Mutual property insurers treat such incidents as legitimate losses and pay without penalty. As long as adjusters are satisfied there was no intent to defraud, they authorize payment in full. Says one supervising adjuster, "It is more likely that one will commit suicide to collect life insurance than property insurance, which he usually shares with a financial institution. He'll destroy his own life, but not his building."

Destruction of one's life, of course, affects life insurance rates, and it is an eventuality considered by actuaries in rate making. Life insurance policies usually contain a "suicide clause" which limits recovery for the first two years to the amount of premium paid in. In cases arising during this "contestable period," it is the company that must prove the death owed to suicide. If the death by suicide occurs after the two-year period, life insurers settle in full. During the depression, life insurance policyholders made a practice of threatening their insurers with suicide unless that got loans or outright payoffs. Today one of the biggest problems involves those who insure their lives to the hilt and then board airliners intent on collecting major insurance indemnities. Such cases have involved bombing of planes and murder of pilots, occurrences federal regulations and insurance practice changes may avert. One suggestion is that air trip insurance be sold only on an annual basis.

Despite the increasing prevalence of suicide, agencies in major cities are making

progress in suicide prevention. Boston, New York, Chicago and Los Angeles have suicide prevention centers, and the Los Angeles unit is making major progress in "in depth" studies of the suicide problem. Units set up emergency telephone numbers that potential suicides may call to get counseling combining the disciplines of psychiatry, psychology and gentle persuasion. Such agencies rest on the proposition, as does insurance, that the instinct for self-preservation is very strong and that most potential suicides are not 100 per cent convinced that they must destroy themselves.

Suicide may masquerade as accidental death in such situations as grade-crossing collisions. Some suicides seek this way out to avert shame for survivors or to leave possible insurance claims.

Pedestrians, depressed and tired of living, sometimes take their lives by stepping into paths of vehicles. Establishing that such incidents are suicide is difficult, even for medicolegal sleuths.

* * *

Death By Default

The public must be protected of course, but isn't there such a thing as over-protection? Certainly it is no problem to prevent the introduction of any drugs with potentially harmful or mildly harmful side-effects. It's simple—just don't develop any new drugs, or at least make it very difficult for a new drug to be tested and/or marketed. The only difficulty here is that many lives and the improved health of many others would be lost by default, that is, drugs that could be of benefit would never be developed. This is just as wrong as allowing anything and everything to be pushed onto the drug market. For the non-medically orientated it is quite easy to understand the sad results of a thalidomide deformed baby but far less easy for many to comprehend the equally sad results of those lives that can be lost by default.—Joseph P. Schaefer, M. D., in *New Physician,* 13: 10, (Oct.) 1964.

Blood and Blood Banking

The American Medical Association will sponsor a Conference on Blood and Blood Banking Dec. 11-12, 1964, in Chicago (Drake Hotel).

The conference is directed to practicing physicians, said Gunnar Gundersen, M. D., chairman of the AMA Committee on Blood, expressing the hope that state and local medical societies will designate representatives to attend.

Objective of the conference is to "motivate the medical profession to evaluate and implement blood banking requirements and to participate generally in local blood banking affairs," Dr. Gundersen said.

The conference will be opened by Raymond L. White, M. D., director of the AMA's Division of Environmental Medicine and Medical Services, and by Dr. Gundersen. Louis K. Diamond, M. D., director of the Blood Grouping Laboratory, Boston, will outline the history of blood banking in the U. S.

A session on "Blood Banking Concepts and Systems," with Thomas D. Kinney, M. D., of Durham, N. C., as moderator, will include discussion of automation, central typing and crossmatching, medical sponsorship and supervision, a report on the Knoxville program, and hospital programs. Another session, with Charles C. Smeltzer, M. D., Knoxville, Tenn., as moderator, will cover the theme of Blood Procurement Concepts and Economics, including the areas of volunteer donor programs, paid donor programs, national clearinghouse program, and blood banking economics.

A session on "Blood Insurance-Assurance Plans," will be moderated by Clyde G. Culbertson, M. D., Indianapolis, Ind. A session on "Standards, Inspection and Accreditation," with Charles E. Rath, M. D., as moderator will open the second day of the conference, and will include a study of state laws and regulations.

Alabama Department of Public Health

TUBERCULOSIS CASE-FINDING PROGRAM IN ALABAMA

W. H. Y. Smith, M. D., M. P. H., Director

Bureau of Preventable Diseases
Alabama Department of Public Health

The objective of all case-finding procedures in Alabama, regardless of the tools used, will be to detect those individuals who have been infected by the tubercle bacillus and those who have active infectious disease. The tools most commonly used to accomplish this objective will be: (1) The tuberculin skin test, and (2) chest x-ray film.

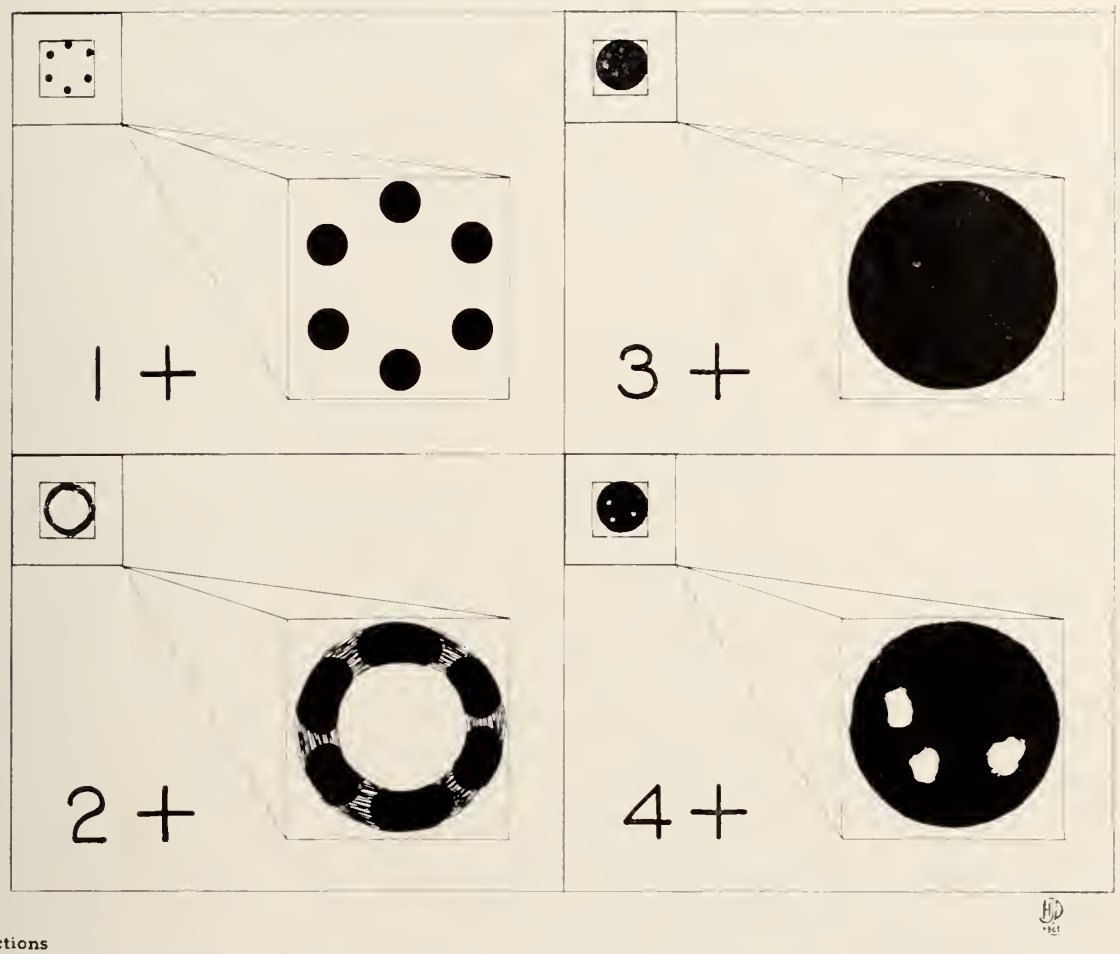
Tuberculin Testing:

Tuberculin testing, as a case-finding procedure, is most effective when done as close to the date of birth as possible. Ideally, all children should be tuberculin tested for the first time when they are six months old. The exception to this would be those children under six months of age, but over three months, in the household of a known active case. Because the incubation period for the tubercle bacillus is six to eight weeks, it is futile to test children under three months of age. The annual retesting of entire student populations, or even just selected grades such as first and seventh grade students, soon becomes an expensive, exhausting, unproductive exercise.

As part of the control of tuberculosis in Alabama, once the infected case is removed from the home the household contacts will be checked in the following way: Those thirteen years of age and under will be tuberculin tested. Those over 14 will be x-rayed. Household contacts under 13, who have a negative tuberculin reaction, household contacts under 13 who have a positive tuberculin test but a negative lung x-ray, and household contacts over 14 who have a negative lung x-ray will be placed on a treatment program of daily drugs, Isoniazid and Pyridoxine, for one year.

The Mantoux test is preferable for tuberculin skin testing. Five tuberculin units, intermediate strength PPD, are used. The test must be read within 72 hours. For any type of mass tuberculin testing, the Mantoux test is preferable, but for use as a mass weapon, Heaf or Tine test should be used. In the Heaf testing, as in the Mantoux, PPD is used. The Heaf test is not an absolutely measured dose as is the Mantoux test, but it is felt that for mass screening it is a very useful tool. Concentrated PPD is used in the Heaf test. This can be applied with a sterile toothpick, or by dipping the head of the sterile cartridge of the Heaf gun directly into a small supply of the antigen used. This test should be read on the fourth day.

HEAF TUBERCULIN TEST---Degrees Of Positive Reactions



Reactions

Negative—No papules or slightly raised papules.
1 plus Positive—4-6 separate indurated papules.
2 plus Positive—Markedly indurated confluent papules.
3 plus Positive—Intensive induration forming coin pattern approximately 1 cm. in diameter.
4 plus Positive—Extensive induration with blisters.

Interpretation of reactions

Severe reactions (2, 3 and 4 degrees positive) are associated with infection by tubercle bacilli. These reactions usually appear within 48 to 72 hours.

Mass tuberculin testing in the schools is decried, except in highly explosive areas with rising incidence of tuberculosis. There is no reason to repeat a negative skin test routinely unless there is reason to believe there have been additional contacts with a case of tuberculosis. Mass x-raying, as a case-finding mechanism, is unprofitable from the cost, the time, and the workers' standpoint.

X-raying:

The mass x-ray approach to tuberculosis had been in operation since 1948 and for years this was an effective weapon in discovering new cases of tuberculosis. In April, 1960, it became reasonably unproductive, therefore a new face was designed for case finding. This consisted of spot x-ray testing and cluster testing. All individuals in these groups who are 13 years of age and younger will not be screened by x-rays but will be tuberculin tested.

This change from the blunder bus to the shot gun and rifle techniques will be successful, it is hoped, if each county will maintain a map spotting each case of tuberculosis reported since January 1, 1960. This gives evidence of high prevalence areas, the grouping of a few cases and the isolated cases that may

constitute the beginning of a focus of infection. For the isolated cases, the clustering technique is the method of choice. The patient, by this technique, is interviewed for direct contacts, intimate relatives and intimate friends, and this variety of contacts is referred to the county health department. Those contacts, 14 years of age and over, are screened by 70 mm x-rays and the younger ones are tuberculin tested.

The grouping of a few cases might be handled by cluster testing only or it might be necessary to do some spot testing also. Spot testing is a type of pin point mass testing in which people in a given limited area are x-rayed and the younger ones tuberculin tested.

In high prevalence areas spot and cluster testing is necessary. The latter type of testing is necessary to be sure that intimate relatives and intimate friends are tested since, quite often, these contacts live outside the area of spot testing.

Modus Operandi: Buses will be maintained in certain areas of the State and x-ray technicians will do the spot and cluster testing. When an area is assigned for x-ray work the technician takes his car to the county designated. After approval by the County Health Officer and the County Medical Society, the technician goes by common carrier to the bus storage depot. If the technician is to accomplish anything at all he must have his car for follow-up work. At the time the 70 mm x-ray clinic is held all 13 year olds and under are tuberculin tested with PPD intermediate strength (1/10,000 mg. PPD, or 5 tuberculin units). The test cannot be given by the technician but must be given by either the health officer, clinician, or nurse. In 48 to 72 hours the test will be read by the tester, who measures the reaction in the following way:

0-4 mm reaction—negative
5-9 mm reaction—doubtful
(Repeat in 3 months)
10 mm and over—positive

Since this primary method of case-finding is successful, the secondary, or diagnostic clinic, is streamlined too. Therefore, the secondary clinic is held two to three weeks later. At this time all individuals, with suspicious readings from 70 mm x-ray films and tuberculin testing, have a 14 x 17 film made. This timing is based on the promise that films taken can be developed the following week and read by the tuberculosis readers. The one week extra is needed to notify those individuals who would be asked to come back for the 14 x 17 film.

Those suspects who need a continuing follow-up and the active cases of tuberculosis found are referred to the county health officer, as is done in the routine diagnostic clinic.

American Board of Obstetrics and Gynecology

Candidates who have participated in the Part I (written) examination of this Board given on December 11, 1964 will be notified of the results of their examination on or before February 1, 1965.

Applications for the Part I (written) examination to be given on July 2, 1965 will be accepted in the office of the Secretary during the months of January and February. All applications postmarked after February 28th will be returned to the sender. Application forms and Bulletins of the Board may be obtained by writing to the office of the Secretary—Clyde L. Randall, M. D., American Board of Obstetrics and Gynecology, 100 Meadow Road, Buffalo, New York 14216.

International Academy of Proctology Seminar

The International Academy of Proctology will present its 17th Annual Teaching Seminar at the Jung Hotel, New Orleans, March 13-18, 1965. All members of the medical profession are cordially invited to attend, whether or not affiliated with the Academy.

Eminent teachers from all parts of the world will lecture on office proctology, psychosomatic aspects of proctology, colon surgery, medical proctology, nuclear medicine in proctology, and there will be many panel discussions.

BUREAU OF LABORATORIES

Thomas S. Hosty, Ph.D., Director

October 1964

Examinations for intestinal parasites	1,194
Typhoid cultures (blood, feces, urine and other)	302
Brucella cultures	1
Examinations for malaria	2
Examinations for gonococci	1,882
Serologic tests for syphilis (blood and spinal fluid)	23,712
Darkfield examinations	9
Agglutination tests	1
Examinations for diphtheria bacilli and Vincent's	151
Complement fixation tests	61
Examinations for Negri bodies (smears and animal inoculations)	237
Water Examinations	2,395
Milk and dairy products examinations	3,653
Examinations for tubercle bacilli	3,538
Miscellaneous examinations	6,357
	43,495

BUREAU OF PREVENTABLE DISEASES

W. H. Y. Smith, M. D., Director

CURRENT MORBIDITY STATISTICS

1964

	Sept.	Oct.	*E. E. Oct.
Tuberculosis	92	120	159
Syphilis	126	163	117
Gonorrhea	257	307	350
Chancroid	1	1	3
Typhoid fever	1	1	5
Undulant fever	0	0	1
Amebic dysentery	11	5	3
Scarlet fever & strep. throat	224	342	66
Diphtheria	5	10	8
Whooping cough	18	20	13
Meningitis	8	11	5
Tularemia	0	0	0
Tetanus	1	1	1
Poliomyelitis	0	0	7
Encephalitis	0	0	1
Smallpox	0	0	0
Measles	24	53	26
Chickenpox	3	10	3
Mumps	15	17	22
Infectious hepatitis	42	62	43
Typhus fever	2	0	1
Malaria	0	0	0
Cancer	646	964	592
Pellagra	1	0	0
Rheumatic fever	10	26	14
Rheumatic heart	36	29	20
Influenza	35	28	31
Pneumonia	124	162	143
Rabies—Human cases	0	0	0
Pos. animal heads	1	2	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

BUREAU OF VITAL STATISTICS

Ralph W. Roberts, M. S., Director

PROVISIONAL BIRTH AND DEATH STATISTICS AND COMPARATIVE DATA, SEPTEMBER 1964

Live Births / Deaths / Causes of Death	Number Registered During September, 1964			Rates* (Annual Basis)		
	Total	White	Non-White	1964	1963	1962
Live Births	6,795	4,302	2,493	24.3	25.4	25.9
Deaths	2,376	1,552	824	8.5	8.5	8.6
Fetal Deaths	123	59	64	17.8	18.3	23.1
Infant Deaths—						
under one month	138	65	73	20.3	19.0	23.0
under one year	195	80	115	28.7	24.9	31.3
Maternal Deaths	7	1	6	10.1	4.2	8.2
Causes of Death						
Tuberculosis, 001-019	15	9	6	5.4	4.7	8.4
Syphilis, 020-029	4	2	2	1.4	1.8	1.8
Dysentery, 045-048	2	1	1	0.7	0.7	0.4
Diphtheria, 055	1		1	0.4		0.4
Whooping cough, 056	2		2	0.7	0.4	
Meningococcal infections, 057	3	2	1	1.1		0.4
Poliomyelitis, 080, 081	1	1		0.4		0.4
Measles, 085						
Malignant neoplasms, 140-205	348	255	93	124.7	123.4	114.4
Diabetes mellitus, 260	29	17	12	10.4	8.3	11.7
Pellagra, 281					0.4	0.7
Vascular lesions of central nervous system, 330-334	333	208	125	119.3	138.6	115.9
Rheumatic fever, 400-402	1		1	0.4	0.4	0.4
Diseases of the heart, 410-443	733	540	193	262.6	275.3	278.4
Hypertension with heart disease, 440-443	93	35	58	33.3	40.4	42.3
Diseases of the arteries, 450-456	44	30	14	15.8	20.6	20.4
Influenza, 480-483	1	1		0.4	1.1	0.7
Pneumonia, all forms, 490-493	51	33	18	18.3	18.0	18.2
Bronchitis, 500-502	4	2	2	1.4	1.8	1.8
Appendicitis, 550-553	6	4	2	2.1	1.4	1.1
Intestinal obstruction and hernia, 560 561, 570	16	12	4	5.7	4.7	2.9
Gastro-enteritis and colitis, under 2, 571.0, 764	12	1	11	4.3	3.2	7.3
Cirrhosis of liver, 581	10	8	2	3.6	5.8	4.0
Diseases of pregnancy and childbirth, 640-689	7	1	6	10.1	4.2	8.2
Congenital malformations, 750-759	31	21	10	4.6	3.8	4.9
Immaturity at birth, 774-776	38	13	25	5.6	6.0	7.6
Accidents, total, 800-962	156	108	48	55.9	55.6	46.3
Motor vehicle accidents, 810-835, 960	79	55	24	28.3	33.6	22.6
All other defined causes	385	242	143	137.9	128.1	129.4
Ill-defined and unknown causes, 780-793, 795	143	41	102	51.2	31.0	55.8

*Rates: Birth and death—per 1,000 population
Infant deaths—per 1,000 live births
Fetal deaths—per 1,000 deliveries
Maternal deaths—per 10,000 deliveries
Deaths from specified causes—per 100,000 population

The Woman's Auxiliary



Dear Doctors:

Merry Christmas!!!

I am sure that your wives are doing what I am doing. They have shoved all of the Medical Auxiliary, P. T. A., and other club work into a nice big drawer and are busy addressing Christmas cards and buying those Christmas presents. Aren't the packages pretty.

There is a beautiful package that you could open that wouldn't have a bill following it the 1st of the next month. Let me tell you about it. It's your local Medical Auxiliary.

Auxiliary comes from the Latin word *Auxiliaris,* which means "help or aid." The plural meaning is "auxiliary troops." As I told you before, our airplane is a Twin Bonanza, and it has main gas tanks and auxiliary gas tanks. One Sunday afternoon we planned to fly to Wichita, Kansas, and eat supper with Lowell's mother. We ran into a front between Memphis and Little Rock that we couldn't go above and couldn't go below. We couldn't go west, we couldn't go north, we couldn't go back east the way we had come. We had to go south and ended up in Greenwood, Mississippi. When we were unloading the six of us, Lowell told the airport attendant to fill the gas tanks, including the auxiliary tanks. Jane, our nine-year-old daughter, got very excited and said, "Momma, is the airplane in the Auxiliary, too?" As you can see, my whole family is Auxiliary-minded right now. Jane's remark brought on a discussion of the word, "auxiliary," and Linda, our thirteen-year-old daughter, provided the definition of the word, "auxiliary," as it is derived from Latin.

Have you opened your Medical Auxiliary package? Do you know what they are doing, what they are capable of doing, rather than individual facets picked up by being the husband of a hard-working Auxiliary member involved in a particular project. Do you know about suggested State and National Auxiliary projects, one of them might fill a local need? Is your Auxiliary the one that raised $562.42 for AMA-ERF? Is your Auxiliary the one with a $7,500 nursing scholarship fund? Is your Auxiliary the one that sent out 8,700 letters in an educational legislative campaign? Is your Auxiliary the one that helped to publicize your local poison control center? These are just a few of the things that I know your wives have done. Our objectives are to assist the Medical Association of the State of Alabama and your local county medical society to:

1. Advance the cause of preventive medicine.
2. Secure adequate medical legislation.
3. Promote good fellowship between physicians' families.
4. Accomplish supplemental work suggested by you.

Now, isn't that a pretty package to open? The best way I know to open this package is to appoint an advisory council to work with your local medical Auxiliary and then have them report back to you at the end of the year.

Sincerely,
Frances Clemmons

P. S. If you don't have a Medical Auxiliary package under your Christmas tree, we will be glad to help your wives organize and wrap one up for you.



The Doctor's Visit, Jan Steen 1626-1679, Mauritshuis, The Hague

In Diverticulosis and Diverticulitis...

METAMUCIL® brand of psyllium hydrophilic mucilloid

"Diverticulosis ...a low-roughage diet is advisable.... Constipation is avoided, preferably by the daily use of Metamucil.

"Diverticulitis Mild, chronic symptoms of diverticulitis, such as diarrhea or flatulence also are treated[1] by low-roughage diet, adequate fluid intake and Metamucil...."

Usual Adult Dosage: One rounded teaspoonful of Metamucil (or one packet of Instant Mix Metamucil) in a glass of cool liquid one to three times daily.

Metamucil is available as Metamucil powder in containers of 4, 8 and 16 ounces and as flavored Instant Mix Metamucil in cartons containing 16 and 30 single-dose packets.

1. Welch, C. E., Diverticula of the Alimentary Tract, in Conn, H. (editor): Current Therapy—1961, Philadelphia, W. B. Saunders Company, 1961, pp. 224-225.

SEARLE

Research in the Service of Medicine

THE ARTHRITICS WHO COULD NOT TAKE STEROIDS

The bane of the steroids, new and old, has been t certain undesirable metabolic effects — including and water retention, edema, overstimulation of appetite, excessive weight gain, mood swing seemed to be firmly linked to the primary a inflammatory action. For arthritics already overwei or with cardiovascular disease complicated by ede or those who were tense and anxious, steroid tr ment could aggravate their problems. But with advent of ARISTOCORT® Triamcinolone, many these arthritics became "steroid-treatable." The r son: Not only did *this* steroid provide gratifying re of inflammation and pain, but it did so *without* penalty of overstimulation of the appetite, exces weight gain, salt and water retention, edema, undesirable euphoria. Six years of widespread use confirmed these benefits for other arthritics as wel those formerly untreatable.



le Effects: Since it may, under some circumstances, oduce many of the unwanted effects common to all rtisone-like drugs, discrimination should always be ercised in administering ARISTOCORT® Triamcino-ne. Any of the Cushingoid effects are possible, as are rpura, G.I. ulceration, increased intracranial pres-re and subcapsular cataract. Corticosteroids gen-ally may mask outward signs of bacterial or viral fections. Catabolic effects to watch for include uscle weakness and osteoporosis. Weight loss may cur early in treatment but is usually self-limiting. *ntraindications:* While the only absolute contra-dications are tuberculosis, herpes simplex and icken pox, there are some relative contraindications eptic ulcer, acute glomerulonephritis, myasthenia gravis, osteoporosis, fresh intestinal anastomoses, diverticulitis, thrombophlebitis, psychic disturbance, pregnancy, infection) to weigh against expected benefits.

A single daily dose may provide effective control, is convenient for the patient, and can be employed in both initial and maintenance therapy.

MAXIMUM STEROID BENEFIT – MINIMUM STEROID PENALTY

Aristocort®

Triamcinolone

scored tablets of 1 mg., 2 mg., 4 mg., 8 mg. or 16 mg.

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$1 = $12½ in Loan-Power...

The American Medical Association's Education and Research Foundation is offering the nation's physicians a chance to stretch their contribution dollars in size and time.

The Foundation is appealing for donations to bolster the guarantee fund for its student loan program, a program providing more than $10 million in bank credit annually for medical students, interns and residents.

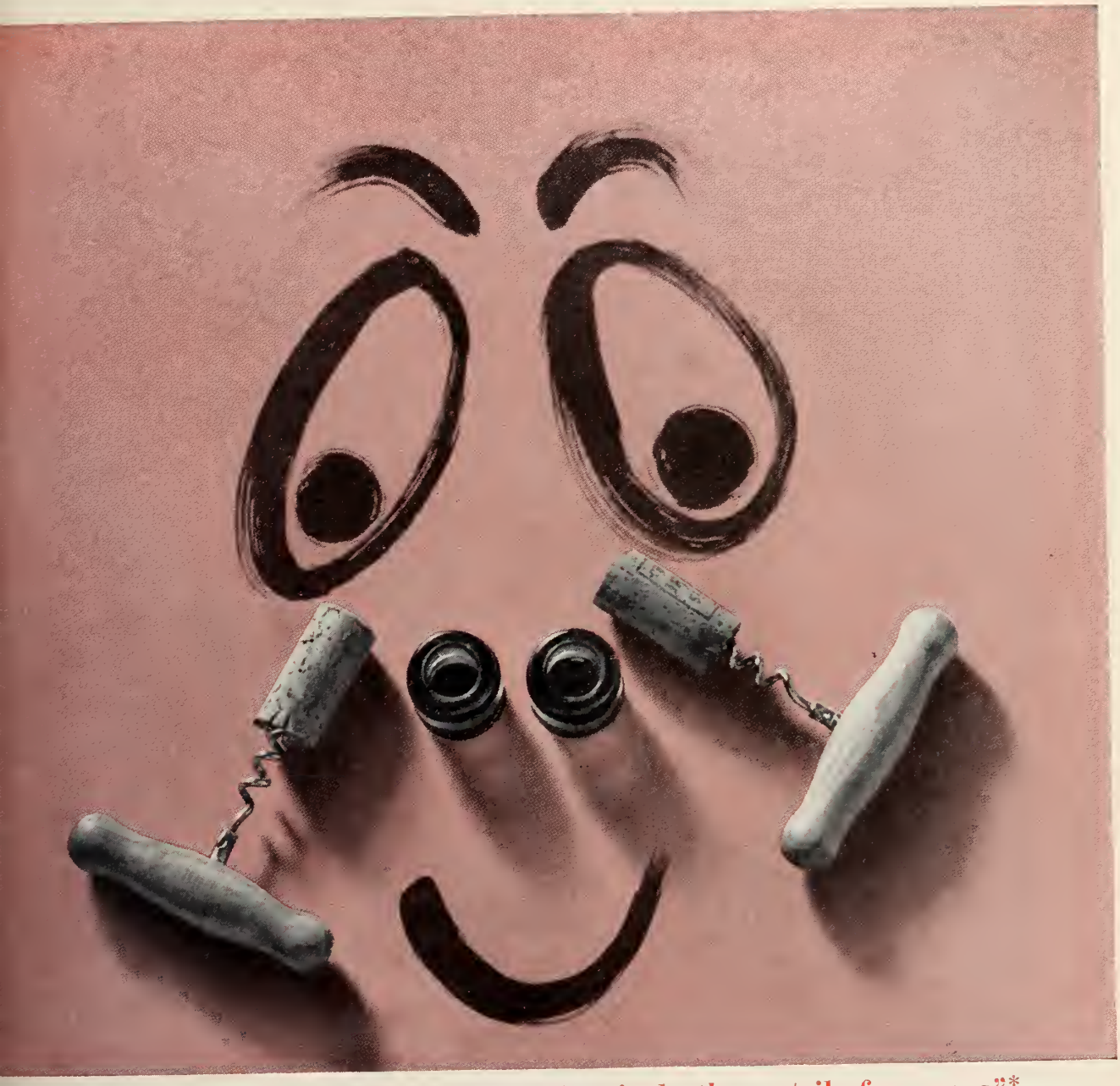
Each dollar a physician gives to the guarantee fund is worth 12½ times its face value in loan-power. That is because the bank will extend $1,250 in credit for each $100 deposit in the fund.

Putting it another way, each $100 contribution can help some student finance about half a year's training and living expenses. The same contribution carries on into the future to guarantee additional loans after the original loan is repaid. And contributions to the fund are tax deductible.

AMA estimates that each year 7,000 applicants will ask for this opportunity to borrow against their future to pay their own way through medical training.

This is a challenge from the coming generation which all physicians should welcome. Certainly there is no better way to put your dollars to work to insure the quality of medicine in the future. Please mail your check today to:

AMERICAN MEDICAL ASSOCIATION
EDUCATION AND RESEARCH FOUNDATION
535 NORTH DEARBORN STREET
CHICAGO, ILLINOIS 60610



"Wonderful...haven't had opening in both nostrils for years"*

(clearly decongested with Dimetapp)

Dimetapp lets your "stuffed-up" patients *breathe easy again.* Each long-acting Extentab works hard for up to 10-12 hours clearing away stuffiness, turning off the drip, and unplugging congestion that accompanies upper respiratory conditions. Yet, patients seldom experience drowsiness or overstimulation. (A key to success: the Dimetapp formula.) Now that the "stuffy" season is here, keep dependable Dimetapp Extentabs on tap. They get the job done.

FOR NASAL DECONGESTION IN SINUSITIS, COLDS, U.R.I.

UP TO 10-12 HOURS' CLEAR BREATHING ON ONE TABLET

Dimetapp® Extentabs®

(Dimetane® [brompheniramine maleate], 12 mg.; Phenylephrine HCl, 15 mg.; Phenylpropanolamine HCl, 15 mg.)

BRIEF SUMMARY: Indications: Dimetapp reduces nasal secretions, congestion, and postnasal drip for symptomatic relief of colds, U.R.I., sinusitis, and rhinitis. **Side Effects:** In high dosages, occasional drowsiness due to the antihistamine or CNS stimulation due to the sympathomimetics may be observed. **Precautions:** Administer with caution in the presence of cardiac or peripheral vascular diseases and hypertension. **Contraindications:** Antihistamine sensitivity. Not recommended for use during pregnancy.

*Clinical report on file, Medical Department, A. H. Robins Co., Inc.

A. H. ROBINS CO., INC., RICHMOND 20, VA.

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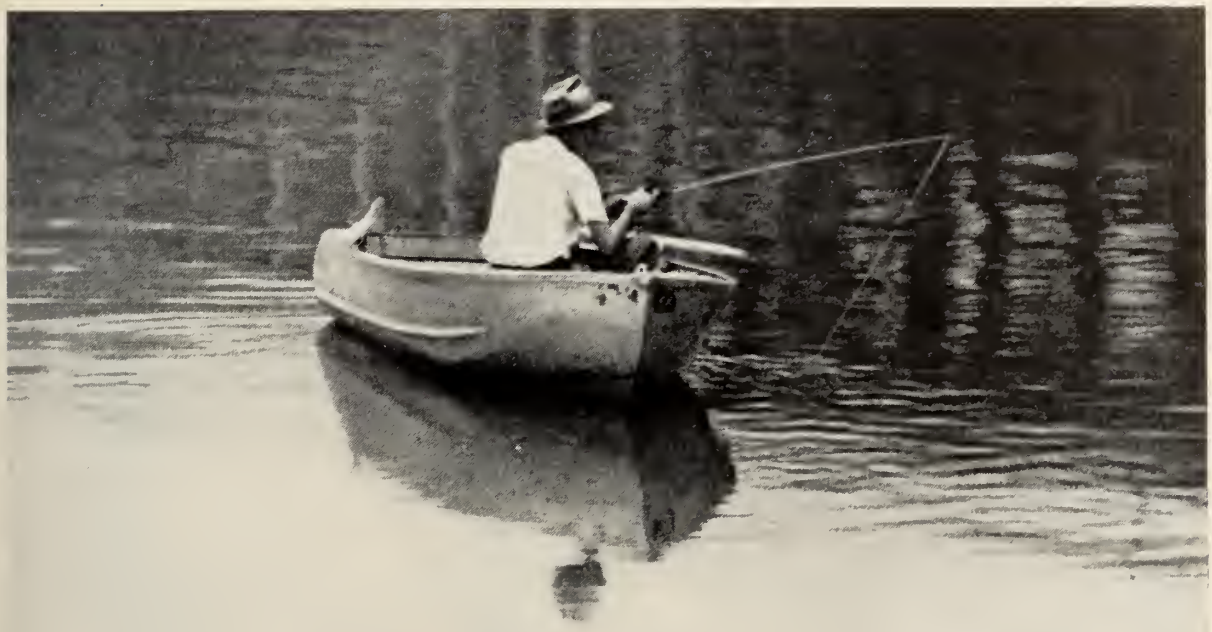
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- **Promotional**

"Your Story in Pictures Leaves Nothing Untold"



The discharged mental patient . . . and Thorazine®

brand of chlorpromazine

"The average practitioner is quite capable of handling the vast majority of ex-institutionalized patients by regulation of medication, reassurance, manipulation of the environment where necessary, and . . . other technics." Kline, N.S.: Postgrad. Med. 27:620 (May) 1960.

The family physician must often assume responsibility for the discharged mental patient. Thorazine (chlorpromazine, SK&F) can be a valuable adjunct to the continuing care of this patient, because it helps prevent relapses by insulating him from the impact of stressful experiences. For successful rehabilitation and prevention of rehospitalization, however, the former mental patient—and often his family—also needs the guidance and counsel of his physician.

Many physicians are surprised by the high doses of Thorazine (chlorpromazine, SK&F) used in patients released to their care from mental hospitals. This surprise may be expressed by a drastic reduction in dosage "to play it safe"—with serious consequences for the patient.

The successful maintenance of former mental patients requires adequate, often "high" dosage, and often for prolonged periods of time. Fortunately, these dosages do not mean greater risks for the patient. On the contrary, there is much less risk of serious side effects once a patient has become gradually accustomed to Thorazine (chlorpromazine, SK&F)—*regardless of dosage*—over a period of a few months. Continuing therapy is almost always well tolerated, and is essential to most patients' continued well-being.

Brief Summary: Thorazine (chlorpromazine, SK&F) has been successfully used for 10 years in the treatment of mental and emotional disturbances, and has proven highly effective in the maintenance therapy of former hospitalized mental patients. *Principal side effects:* The most frequently encountered side effect is transitory drowsiness. Other occasional side effects include: dry mouth, nasal congestion, constipation, miosis, dermatological reactions, photosensitivity, jaundice, hypotension, increased appetite and weight; very rarely, mydriasis, agranulocytosis, extrapyramidal symptoms. *Contraindications:* Comatose states or in the presence of excessive amounts of C.N.S. depressants.

For complete prescribing information, please see *PDR* or available literature.

SK&F *Smith Kline & French Laboratories*

why does 150 mg.



do more than 250 mg.



of other tetracyclines?

Because it has up to 3½ times the *in vitro* antibacterial activity[1]...combined with lower rate of decay in serum, slower renal clearance...a favorable depot effect, resulting from protein binding...all providing rapid, higher and sustained *in vivo* activity with as much as 2 days' extra activity.

DECLOMYCIN®

DEMETHYLCHLORTETRACYCLINE HCl

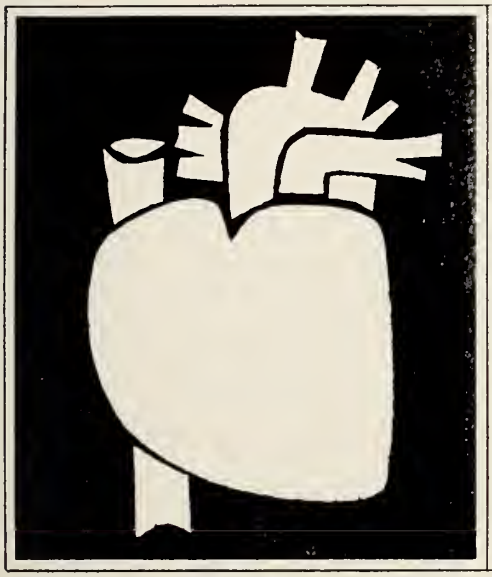
Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive. **Side Effects** typical of tetracyclines which may occur: glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms. Also: photodynamic reaction (making avoidance of direct sunlight advisable) and, very rarely, anaphylactoid reaction. Reduce dosage in impaired renal function. The possibility of tooth discoloration during development should be considered in administering any tetracycline in the last trimester of pregnancy, in the neonatal period, and in early childhood. *Capsules,* 150 mg. and 75 mg. of demethylchlortetracycline HCl. *Average Adult Daily Dosage:* 150 mg. q.i.d. or 300 mg. b.i.d. 1. Sweeney, W. M.; Dornbush, A. C., and Hardy, S. M.: Demethylchlortetracycline and Tetracycline Compared. Relative *in vitro* Activity and Comparative Serum Concentrations During 7 Days of Continuous Therapy. *Amer. J. Med. Sci.* 243:296 (Mar.) 1962.

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A CONSERVATIVE Rx FOR A CLASSIC Dx



SUDDEN ONSET
ANTERIOR
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MILTRATE®

meprobamate 200 mg. + pentaerythritol tetranitrate 10 mg.

Effective tranquilization plus long-acting coronary vasodilation for prophylaxis of pain in angina pectoris

Indications: 'Miltrate' is useful for prophylaxis of pain in angina pectoris and coronary insufficiency, especially where anxiety is a factor. **Contraindications:** Like all nitrates, pentaerythritol tetranitrate should be avoided or prescribed cautiously for patients with glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use. **Precautions:** *Meprobamate* —Patients engaged in activities requiring alertness should be warned of drowsiness. Meprobamate may increase the effects of excessive alcohol, and the possibility of dependence should be considered, particularly in patients with a history of drug or alcohol addiction. Sudden withdrawal may result in reactions, rarely epileptiform seizures. Grand mal attacks may be precipitated in persons susceptible to both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies. **Side effects:** *Pentaerythritol tetranitrate* —The most common side effects are transient headache, nausea, and rash. Weakness, palpitation, flushing, gastrointestinal distress, and lightheadedness have been reported on a few occasions. *Meprobamate* —May cause drowsiness and, rarely, ataxia, usually controlled by decreasing the dosage. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses of the drug. Mild reactions include urticarial or maculopapular rash. Serious reactions, rarely encountered, include dermatological effects, acute nonthrombocytopenic purpura, chills, fever, fainting spells, angioneurotic edema, bronchial spasm, hypotensive crisis, anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic, and the drug not be reinstituted. **Dosage:** Usual dosage is one or two tablets before meals and at bedtime. Individualization of dosage is required for maximum therapeutic effect. Doses above twelve tablets daily are not recommended. **Supplied:** White tablets, each containing meprobamate 200 mg. and pentaerythritol tetranitrate 10 mg.
Before prescribing, consult package circular.

WALLACE LABORATORIES / Cranbury, N. J.

CML-4087

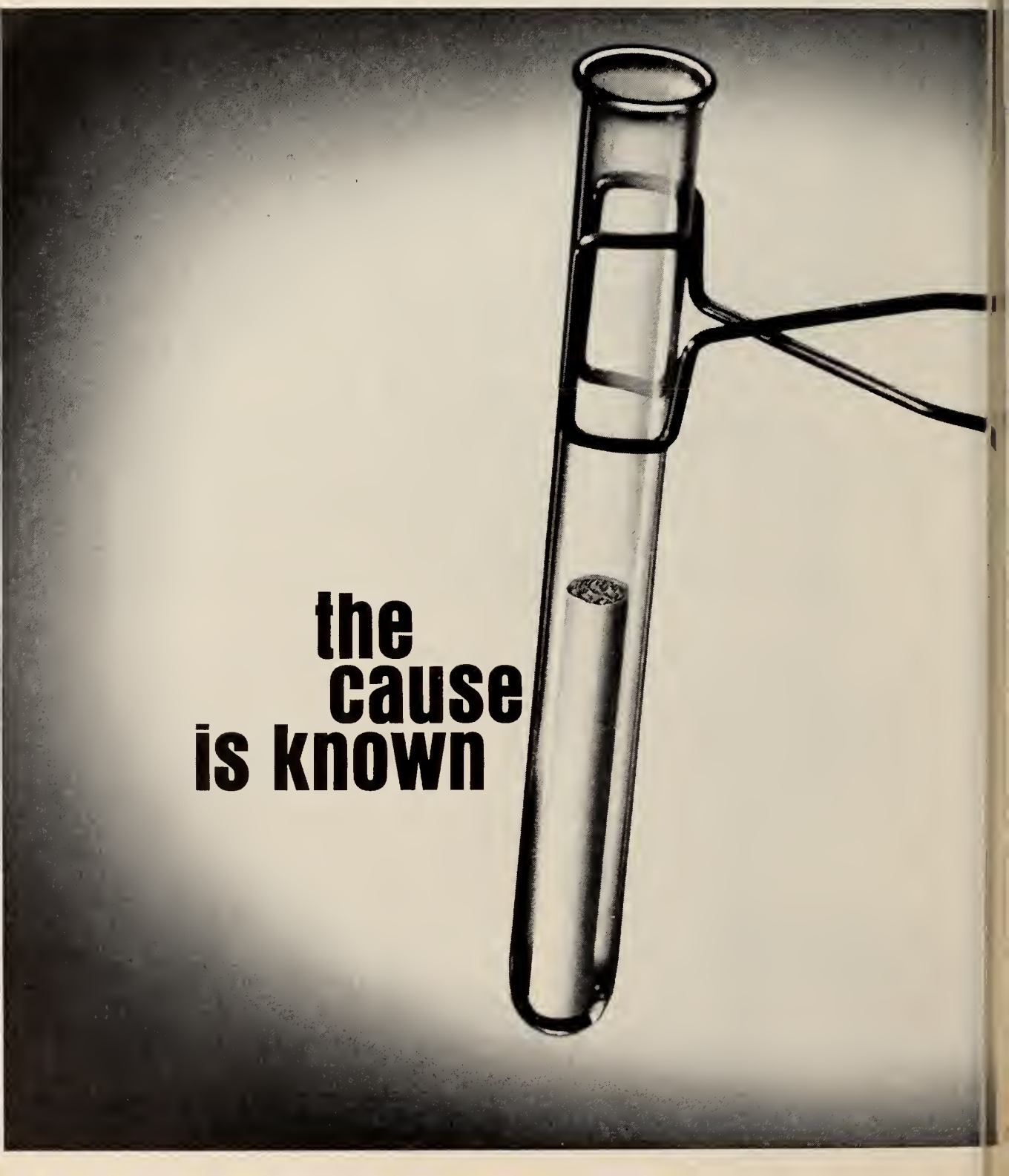
The big question has been answered for many people. The report of the Surgeon-General on Smoking and Health gave strong support to the overwhelming evidence accumulated by the American Cancer Society over the last 15 years. Cigarette smoking is a major cause of lung cancer.

As the evidence piled up, the Society intensified its public educational efforts, with teen-agers the specific target. Many private and government agencies were stimulated to take action.

But people have short memories. Already the message of the Surgeon-General's report has been blurred with the passage of time. Unless those with the responsibility for protecting health act vigorously, the public will continue to lose sight of the risk . . . and smoke cigarettes.

We are faced with some compelling questions. How to motivate adults to stop smoking cigarettes? How to influence teen-agers not to start? How to help those who want to stop but can't?

Between us, doctor, we must find the answers. **american cancer society**





Bed of Digitalis purpurea
with Campanula (Canterbury Bells) in foreground

Not far from here are manufactured
from the powdered leaf
Pil. Digitalis (Davies, Rose)
0.1 Gram (1½ grains) or 1 U.S.P. Digitalis Unit.
They are physiologically standardized,
with an expiration date on each package.
Being Digitalis in its completeness,
this preparation comprises the
entire therapeutic value of the drug.
It provides the physician with a safe and effective
means of digitalizing the cardiac patient
and of maintaining the necessary saturation.
Security lies in prescribing the
"original bottle of 35 pills, Davies, Rose."

Clinical samples and literature sent to physicians on request

Davies, Rose & Co., Ltd. Boston 18, Mass.

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Outwardly calm...but what goes on inside?

Appearances on the outside do not necessarily suggest what goes on inside. This is particularly true of the ulcer patient, who may appear jolly and unruffled to his neighbors, but presents to you the classic symptoms: organic and functional disorders of the G.I. tract, associated with anxiety and tension.

Consider, when you see him next, the value of PATHILON® SEQUELS® with Phenobarbital, which provides sustained anticholinergic protection from spasm and pain in the target areas, as well as sustained phenobarbital action against triggering anxiety. The controlled release of the active ingredients in the SEQUELS® formulation means protective medication day and night.

Effective in peptic ulcer, intestinal colic, ileitis, esophageal spasm, spastic colon, alcohol-induced G.I. upsets, gastric hypermotility and anxiety neurosis with G.I. symptoms. Should be used as adjunct to other measures.

Side Effects (due to tridihexethyl chloride): dry mouth, blurring of vision, constipation.

Contraindications: urinary bladder neck obstruction; glaucoma; obstructive congenital anomalies of the gastrointestinal tract; pyloric obstruction; congenital megacolon; and stenosing gastric or duodenal ulcer with significant gastric retention.

Also available, without phenobarbital, as PATHILON® Tridihexethyl chloride SEQUELS® 75 mg.

Pathilon® Sequels® with Phenobarbital Sustained Release Capsules

Each capsule contains: Tridihexethyl chloride, 75 mg., and phenobarbital, 45 mg.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

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Your patient doesn't have to be in the Masters to get sprains and strains

Regardless of the etiology of muscle sprain or strain, 'SOMA' COMPOUND helps relieve pain and relax muscle. Patient comfort can be increased and recovery time shortened.

Soma® Compound

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

rational combination therapy for sprains and strains: relaxes muscle, relieves pain. Also available with ¼ gr. codeine as 'SOMA' COMPOUND with CODEINE: carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning: may be habit-forming.)

BRIEF SUMMARY

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Side effects: In clinical use, fatigue, drowsiness and ataxia have been reported; in most instances these are dose-related and may be avoided by proper dosage adjustment. Mild nausea and dizziness may occur on occasion. As with any new agent, when it is administered for protracted periods of time, periodic blood counts and liver function tests are advisable. Abrupt cessation after prolonged overdosage may, in some patients, produce withdrawal symptoms (*e.g.,* convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and Librium® (chlordiazepoxide HCl). Changes in EEG patterns have been observed in patients during and after Valium (diazepam) treatment.

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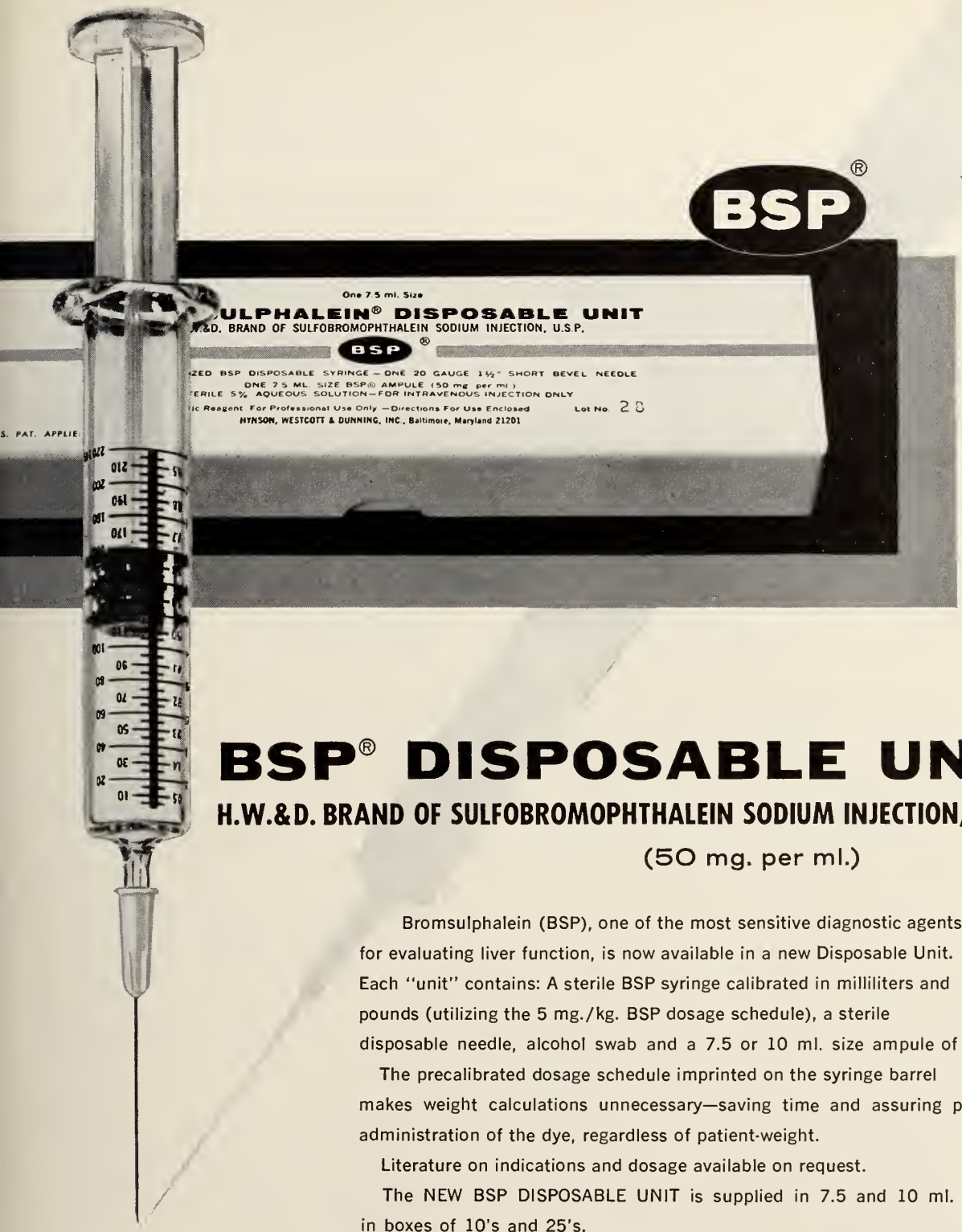
Precautions: Toxic effects are infrequent: allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Eruptions then usually subside. Though mild and rarely an indication for stopping dosage, gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered, especially in children, adolescents, and young adults. During initial treatment, minor side effects may include gastric distress, nausea, weight loss, transient nervousness, sleeplessness, and a feeling of unsteadiness. All usually subside with continued use. Megaloblastic anemia, aplastic anemia, leukopenia, granulocytopenia and pancytopenia have been reported. Nystagmus may develop. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. Periodic examination of the blood is advisable.

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*Roseman, E.: *Neurology* **11**:912, 1961. 33664

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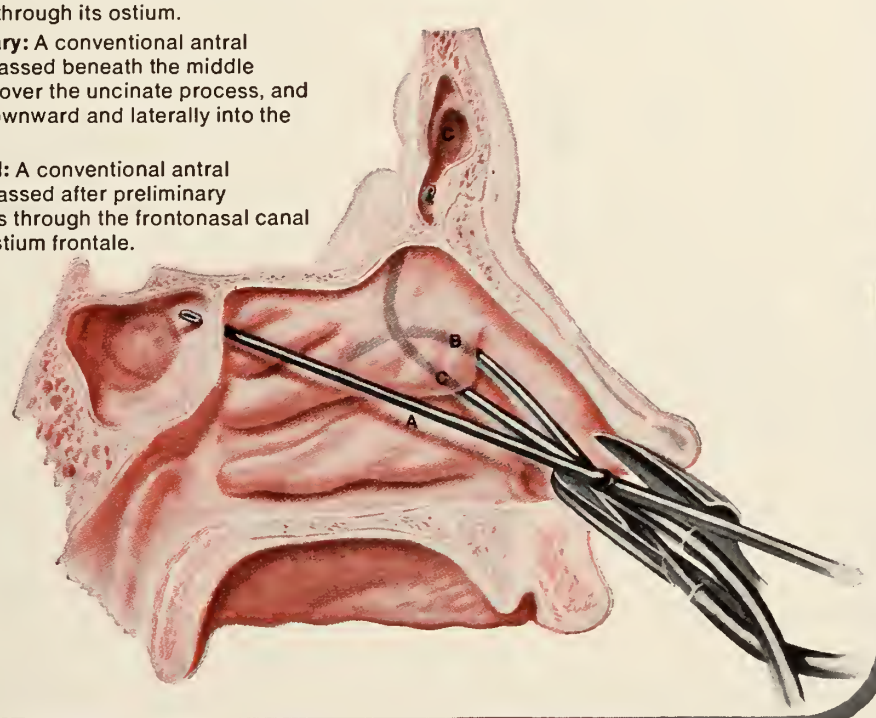
Woman's Auxiliary 216

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*Reed, G. F.: Sinusitis, New England J. Med. 267:402, Aug. 23, 1962.

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President's Page

This begins the new calendar year with the inauguration of a President and a new Congress, the 89th. The former now has the power of a war-time Chief Executive with a Congress that can be dangerously careless since one party has so much power, seemingly, at the moment. The ultra-conservative may not have a place now, but surely the moderate does not either. Only the liberal appears to be correct in his viewpoint by the fact that in all but the five Southern States the "Democrats" beat the "Republicans." It is interesting to note that these majorities were not overwhelming except possibly in large urban areas where the vote might have been 2-1. We had previously mentioned in other editorials that Johnson felt if he had a large majority when the votes were in then he would consider it a mandate to proceed with his program.

The King-Anderson legislation and the Poverty Program were the only ones not approved by the 88th Congress before it adjourned. Johnson appeared frustrated because the Medical Care for the Aged under Social Security was not passed. Suddenly, since the election, he is sending up trial balloons and appearing to suggest some type of insurance plan that will not bankrupt the Social Security program. Serious thought should be given to this line of thinking of his.

Thus we come to the Clinical Meeting of the American Medical Association in Miami this past December. There we heard from several delegations. District of Columbia, New Jersey, and Michigan numbered among those who are beginning to advocate compromise from organized medicine's standpoint. Fortunately this nation is made up of many states and many people. The policy of compromise is an indication of weakness if it is entered into just to get on the bandwagon, and to yield to pressure because it is the easiest way out. Our only position at the moment is to stick to our guns. If we give this fight away at this point then we deserve to be ignored from now on when we oppose socialization.

There are three points to the AMA program before Congress meets:

1. A strategy meeting in Chicago which was held December 13, 1964. Seven of our members attended this, the President, Secretary-Treasurer, two members of the Board of Censors, the executive secretary of the State Association, the President-elect of the Jefferson County Medical Society and the executive secretary of the Jefferson County Medical Society. AMA only asked for two to attend, but the interest was too keen for the others not to go. The advantages of several members' going rested in the fact that more individuals could compare notes and help determine policy for our Association at a later date when the need arises to get out information.

2. About January 10, 1965 the educational program will start. This will show the public on the broadest scale possible what it means to defeat the medicare proposal—and prevent bankruptcy of the Social Security System. It will be directed to encourage the local programs to work, namely under Kerr-Mills.

3. Then finally, if necessary, AMA will have each Congressman contacted personally to impress on them individually the doctor's opposition to any wrong type of legislation.

With this approach by the AMA, we should be able to keep any radical measures from being passed. It is significant that the District of Columbia physicians advocated a type of coverage under Social Security. But it is perfectly obvious why they did this. The majority of the population in the District are employees of the Federal Government under Social Security. And so it is in a welfare state, the Government takes care of everything and everybody. But then you must do what the Government says from "now to eternity."

E. B. Glenn, M. D.

FAMOUS ALABAMA PHYSICIANS

The *New York Evening Post*, on November 26, 1886, carried the following statement:

"In the care of the insane, Alabama stands among the foremost states of the Union. Dr. P. Bryce, the Superintendent of the Insane Hospital, holds a high rank among alienists. Dr. Bryce was one of the earliest and strongest advocates of reform in the matter of mechanical restraint. Five years ago the old strait-jacket system was abolished in his institution. . . . . With the exception of the occasional confinement to his room of a maniacal or excited patient, there has been no restraint of any kind upon the patients in the hospital, and the excellent results of the experiment have convinced Dr. Bryce that no greater advance has been made in the treatment of the insane within the past fifty years than the abolition of mechanical and other unnecessary restraints."



Peter Bryce was born in Columbia, South Carolina, on March 5, 1834. His early education was received in the schools of that city and at the South Carolina Military Academy, The Citadel, from which he was graduated in November, 1855.

In 1857 he enrolled in the Medical Department of the University of New York and received the degree of Doctor of Medicine in March, 1859.

Upon his graduation, Dr. Bryce, having previously determined to make a specialty of nervous diseases, became assistant physician at the Insane Hospital of New Jersey.

Later in 1859 he became first assistant physician of the South Carolina State Hospital; but within a month, upon the suggestion of Miss Dorothea Lynde Dix, famed philanthropist and humanitarian, he applied for the position of superintendent of the newly-constructed Alabama Insane Hospital at Tuscaloosa.

His application was accepted and he became head of the institution at the age of 26.

One of his first actions was to abolish all mechanical restraints and to find employment for every patient to keep him occupied and happy. To the surprise of many, these innovations did not require the administration of more q u i e t i n g drugs, rougher handling, or longer seclusion of the patient.

Dr. Bryce was active in the Medical Association of the State of Alabama, serving as president in 1877. He participated in many other activities and was a leader in the state temperance movement.

He was married to Miss Ellen Clarkson of Columbia, South Carolina, on November 28, 1860.

Dr. Peter Bryce died August 14, 1892, and was interred on the lawn in front of the hospital he made famous. The following year the Alabama Legislature renamed the institution the Alabama Bryce Insane Hospital.

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*Adams, J.: J. Tenn. Med. Ass. 50:446, Nov., 1957.

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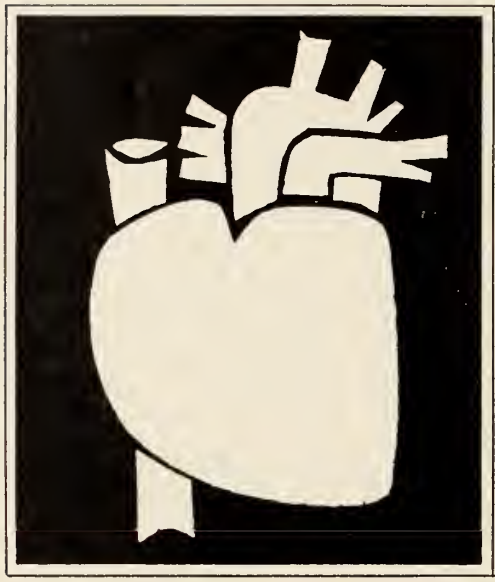
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prophylaxis of pain in angina pectoris

Indications: 'Miltrate' is useful for prophylaxis of pain in angina pectoris and coronary insufficiency, especially where anxiety is a factor. **Contraindications:** Like all nitrates, pentaerythritol tetranitrate should be avoided or prescribed cautiously for patients with glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use. **Precautions:** *Meprobamate* — Patients engaged in activities requiring alertness should be warned of drowsiness. Meprobamate may increase the effects of excessive alcohol, and the possibility of dependence should be considered, particularly in patients with a history of drug or alcohol addiction. Sudden withdrawal may result in reactions, rarely epileptiform seizures. Grand mal attacks may be precipitated in persons susceptible to both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies. **Side effects:** *Pentaerythritol tetranitrate* — The most common side effects are transient headache, nausea, and rash. Weakness, palpitation, flushing, gastrointestinal distress, and lightheadedness have been reported on a few occasions. *Meprobamate* — May cause drowsiness and, rarely, ataxia, usually controlled by decreasing the dosage. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses of the drug. Mild reactions include urticarial or maculopapular rash. Serious reactions, rarely encountered, include dermatological effects, acute nonthrombocytopenic purpura, chills, fever, fainting spells, angioneurotic edema, bronchial spasm, hypotensive crisis, anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic, and the drug not be reinstituted. **Dosage:** Usual dosage is one or two tablets before meals and at bedtime. Individualization of dosage is required for maximum therapeutic effect. Doses above twelve tablets daily are not recommended. **Supplied:** White tablets, each containing meprobamate 200 mg. and pentaerythritol tetranitrate 10 mg.
Before prescribing, consult package circular.

WALLACE LABORATORIES / Cranbury, N. J.

CML-4087



Of 1,028 patients with confirmed respiratory infections... 954 or 92.8% were treated successfully with Signemycin®

Note:
Hammerl* selected his patients for treatment with Signemycin on the basis of demonstrated bacteriological resistance to other antibiotics or failure of previous therapy. Of 100 patients with various respiratory tract infections, 95 responded to Signemycin. Pathogens isolated included staphylococci and *Diplococcus pneumoniae*.

*Hammerl, H.: Wien. Med. Wschr. 108:629, July 26, 1958.

Condition	No. of Patients	No. Responded To Signemycin®
Abscess, pulmonary	17	16
Bronchiectasis	19	13
Bronchitis	286	267
Bronchopneumonia	192	179
Empyema	12	11
Pneumonia, lobar	150	146
Pneumonia, other febrile	160	150
Various infected pneumopathies	192	172
Totals	1,028	954 (92.8%)

consistently effective...often when others fail

Signemycin®

tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Also available as Syrup, Pediatric Drops, and half-strength Capsules

Brief Summary and Bibliography follow.

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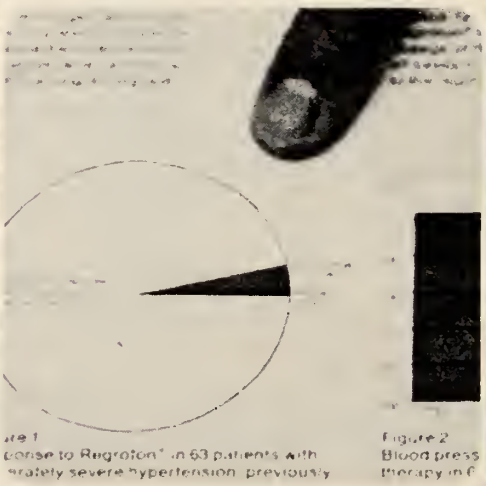
Not *another* reserpine-diuretic combination!



Certainly. Regroton has outperfor other combinations.



Says who?



Says this 2-year study by Finnerty.



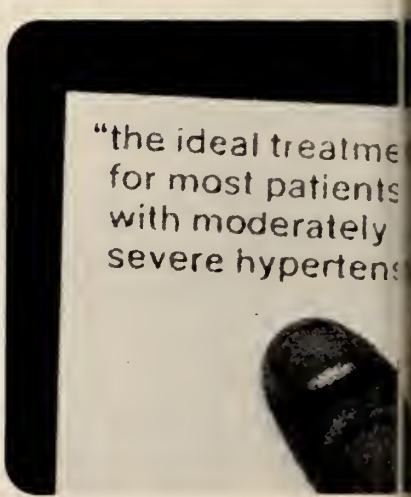
What's the dosage?



Just one tablet with breakfast.



Sounds ideal!



That's what they say.

Composition: Each tablet contains chlorthalidone, 50 mg., and reserpine, 0.25 mg.
Contraindications: History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.
Warning: Discontinue 2 weeks before general anesthesia, 1 week before electroshock therapy, and if depression or peptic ulcer occurs.
Precautions: Reduce dosage of concomitant antihypertensive agents by one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take particular care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.
Side Effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.
For full details, see the complete prescribing information.

Availability: Bottles of 100 and 1000 tablets.
Average Dosage: One tablet daily with brea

*Chupkovich, V.; Finnerty, F. A., Jr., and Kakaviatos, N.: The value of chlorthalidone reserpine in moderately severe and severe tension: A two year study. Presented at the Inter-American Congress of Cardiology, Mc June 14–19, 1964.

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Regroton®

"the ideal treatment for most patients with moderately severe hypertension"*

Geigy



Of 1,021 children with various confirmed infections... 950 or 93.0% were treated successfully with Signemycin®

Note:
The effectiveness of Signemycin was demonstrated by Chattas and his co-workers* who administered Signemycin to 30 children with serious staphylococcal infections resistant to commonly used antibiotics. Only one failed to respond. In each case the use of this drug was indicated by antibiogram. Those children treated with a nonselected antibiotic—for comparative purposes—took three times longer to recover.

Chattas, A. et al.: Antibiot. Med. 7:300, May, 1960.

Condition	No. of Patients	No. Responded To Signemycin®
Eye, ear, nose, throat infections	368	343
Respiratory infections	369	346
Gastrointestinal infections	42	30
Skin and soft-tissue infections	38	37
Deep-seated or generalized infections	47	44
Various conditions	157	150
Totals	1,021	950 (93.0%)

consistently effective...often when others fail

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tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Signemycin is also available as half-strength Capsules, preconstituted raspberry-flavored Syrup and Pediatric Drops

Brief Summary and Bibliography follow.

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SIGNEMYCIN®

Side Effects: Glossitis and allergic reactions, as well as severe anaphylactoid reactions, have been reported as rare side effects. Should significant reaction or idiosyncrasy occur, discontinue medication and institute countermeasures. Use of tetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. Reduce usual oral dosage and consider serum level determinations in patients with impaired renal function to prevent possible liver toxicity due to excessive accumulation of antibiotic in the serum.

Precautions: Overgrowth of nonsusceptible organisms may occur. In such cases, discontinue medication and institute appropriate specific therapy as indicated by susceptibility testing. Aluminum hydroxide gel given with antibiotics has been shown to decrease their absorption and is contraindicated. The coloring agents used in Signemycin Syrup and Pediatric Drops may produce red discoloration of stools.

Triacetyloleandomycin, a constituent of Signemycin, administered to adults in daily oral doses of 1.0 Gm. (3 Gm. Signemycin) for periods of more than ten days may produce hepatic dysfunction and jaundice. In the rare patient who requires this high dosage level of Signemycin initially, liver function should be carefully followed and dosage should be reduced, as promptly as possible, to the usual recommended range of 1.0 to 2.0 Gm. per day. Therefore, Signemycin is recommended primarily for the treatment of acute or severe infections, with treatment restricted to a ten-day period. If clinical judgment dictates continuation of therapy beyond ten days, serial monitoring of the liver profile should be carried out, including BSP, transaminase, and cephalin flocculation tests. Changes observed in liver function were reversible following discontinuation of the drug.

Formulas: Capsules: 250 mg. Signemycin (167 mg. tetracycline HCl and 83 mg. oleandomycin as triacetyloleandomycin).

Capsules: 125 mg. Signemycin (83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin).

Syrup: 125 mg. Signemycin (tetracycline equivalent to 83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin) per 5 cc.

Pediatric Drops: 100 mg. Signemycin (tetracycline equivalent to 67 mg. tetracycline HCl and 33 mg. oleandomycin as triacetyloleandomycin) per cc.

More detailed professional information available on request.

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Of 5,057 patients with confirmed infections of all body systems... 4,731 or 93.5% were treated successfully with Signemycin®

Note:

The high rate of response to Signemycin in these cases is noteworthy because the totals include many patients with difficult-to-treat infections, many whose infections had proved resistant to other agents, and many who had been treatment failures on other therapy.[1-87] In addition the following criteria were used for the cases cited: (1) only published results were used (2) results were confirmed by clinical and/or laboratory findings (3) patients were cured, not "improved" (4) dosage conformed with current recommendations in the United States (5) no other anti-infective agents were used concomitantly (6) no instance of prophylactic use was included in these tabulations.

Condition	No. of Patients	No. Responded To Signemycin®
Ear, nose and throat infections	507	465
Respiratory infections	1,028	954
Gastrointestinal infections	425	387
Genitourinary infections	748	684
Skin and soft-tissue infections	1,088	1,036
Bone and joint infections	71	64
Deep-seated or generalized infections	257	251
Obstetrical & gynecological infections	341	320
Miscellaneous conditions	592	570
Totals	5,057	4,731 (93.5%)

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tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

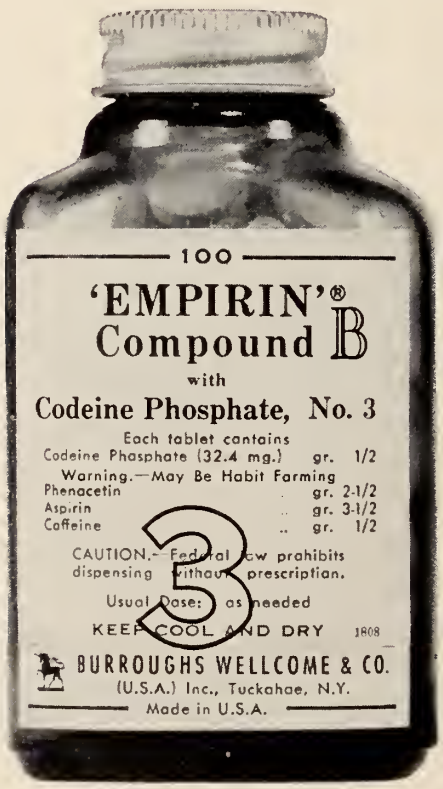
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REASSURING SAFETY FACTORS

Effectiveness, dependability and reassuring Safety Factors make PABALATE-SF a logical choice for antiarthritic therapy in elderly patients—even when osteoporosis, hypertension, edema, peptic ulcer, cardiac damage, latent chronic infection and other common geriatric conditions are present. The potassium salts of PABALATE-SF cannot contribute to sodium retention... the enteric coating assures gastric tolerance... and clinical experience shows that this preparation does not precipitate the serious reactions often associated with corticosteroids or pyrazolone derivatives.

Side Effects: Occasionally, mild salicylism may occur, but it responds readily to adjustment of dosage. Precaution: In the presence of severe renal impairment, care should be taken to avoid accumulation of salicylate and PABA. Contraindicated: An hypersensitivity to any component.

Also available: PABALATE—when sodium salts are permissible. PABALATE-HC—Pabalate-SF with hydrocortisone.

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In each persian-rose enteric-coated tablet: potassium salicylate 0.3 Gm., potassium aminobenzoate 0.3 Gm., ascorbic acid 50.0 mg.

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because food is a factor

in oral penicillin therapy...



This is the breakfast used in the Griffith and Black study reported here.

consider V-CILLIN K®

POTASSIUM PHENOXYMETHYL PENICILLIN

Acid-stable V-Cillin K is much less affected by gastric acids than is oral penicillin G. In fact, comparative data show that V-Cillin K given with meals produces blood levels *twice* as high with just *half* the dose. Such pharmacologic characteristics provide your patients consistently dependable therapy. In addition, significant economy is achieved, since three to four times as much oral penicillin G is required to assure equivalent antibacterial activity.[1]

1. Griffith, R. S., and Black, H. R.: Current Ther. Res., *6*:253, 1964.

Indications: V-Cillin K is an antibiotic useful in the treatment of streptococcus, pneumococcus, and gonococcus infections and infections caused by sensitive strains of staphylococci.

Precautions: Although sensitivity reactions are much less common after oral than after parenteral administration, V-Cillin K should not be administered to patients with a history of allergy to penicillin. As with any antibiotic, observation for overgrowth of nonsusceptible organisms during treatment is important.

Usual Dosage Range: 125 mg. (200,000 units) three times a day to 250 mg. every four hours.

Supplied: Tablets V-Cillin K, 125 or 250 mg., and V-Cillin K, Pediatric, 125 mg. per 5-cc. teaspoonful, in 40, 80, and 150-cc.-size packages.

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Symposium on Mental Retardation

Psychological Evaluation in Mental Retardation

Mary I. Duwall, Ph.D.

The criteria which are to be utilized in making the diagnosis of mental retardation are still in the process of being defined in the United States. Certainly, there are criteria which are agreed upon in medicine, in psychology, and in education, but there is much work to be done and much knowledge to be attained before we achieve clearly-defined criteria which will be accepted by all professional groups working in the area of mental retardation. With a high degree of confidence, we can say that a severely intellectually limited individual is mentally retarded and perhaps even give a clear-cut reason for his retardation. However, as we move away from the severely mentally retarded group and move towards the group which is endowed with average intellectual ability our diagnostic problems increase in complexity. The differences in behavior decrease and the information needed for diagnosis increases. Often the skills of various disciplines are called upon and prolonged study may be indicated before a definite diagnosis can be made.

If you have followed the development of the field of mental retardation, I feel sure that you are aware of how we skillfully sidestepped the problem of our limited knowledge concerning mental deficiency. Since the term mental deficiency implied an essentially incurable condition due to arrested mental development which was of constitutional origin, we avoided committing ourselves to this poor prognosis and began to talk about mental retardation. We moved away from labels such as moron, imbecile, and idiot and began to classify the mentally retarded according to their probable potentiality for learning. Actually, I highly approve of a more positive trend in labels and attitudes but we should face the fact that new labels failed to define the problem more adequately. Oh, we avoided making some mistakes, but at the same time we also offered false hope in some cases.

Apparently, the Russians have used even more finesse when confronted with the problem of mental retardation. The concept is just not accepted. The problem is an educational one and unfortunately traditional educational methods are just not suited to all Russian children. Therefore, ways must be found to develop the potentialities of these children who learn in a different manner. Since each Russian citizen finds fulfillment in making a contribution to the State, the State has the responsibility of developing ways which will enable each individual to make worthy contributions which will give him feelings of worth and satisfaction.

Of course, I have given you an oversimplified, capitalistic interpretation of the Russian position but it is a reasonably accurate one. I assume that some of the more severely mentally retarded cases are classified according to medical diseases and the lack of intellectual development is ignored.

In England, a Mental Deficiency Act was passed in 1913 and even though it has gone through a series of revisions, the emphasis continues to be on social competence. The term "feeble-minded" is applied to individuals we have in the past called morons and now refer to as the educable mentally retarded. Since the intelligence quotient is of secondary importance, an individual with an I. Q. of 90 would be called "feeble-minded" if he failed to make an adequate adjustment in terms of being responsible for his behavior and welfare as an adult. At the same time, an individual with an intelligence quotient considerably below 70 might *not* be considered mentally defective if he were able to maintain himself socially and financially.

The strong emphasis on intelligence test scores is an American phenomenon. Unfortunately, they are sometimes used to make important decisions even though they are poorly understood. Recognition of the fact that a mental age score or an intelligence quotient is arrived at by inference rather than direct measurement should encourage caution, but often this is not the case. Leaders in the field of mental retardation have deplored the tendency to make decisions on the basis of a test score alone, but the practice continues. In our educational system, a 2 point difference in intelligence quotient can determine the type education a mentally retarded child will receive. At times, eligibility for institutional care may be determined by a difference of less than 5 I. Q. points.

Can you imagine what would happen if a Russian, an English and an American group of professional people met to discuss mental retardation? We would have about as little agreement on who should be labelled retarded as we have when issues are discussed in the United Nations meetings. However, if one is merely an observer of the discussion, he can accept the viewpoint of each group. Then he can go a step further and become concerned with causative factors of mental retardation, the methods of determining these, and the methods of preventing retardation. Actually, this approach is being used in most countries today, even though we find the usual cultural lag in the application of available knowledge.

At this point, I would like to talk about psychological evaluation of the mentally retarded pre-school child. I have chosen this particular group of children because I work with them and because they contribute a great deal in discouraging rigid adherence to a one-or-two factor approach to mental retardation. Much of what will be said can be applied to the field of mental retardation in general if slight modifications are made.

Adequate psychological evaluation of a mentally retarded pre-school child should include an assessment of intellectual, social, and emotional development. The psychologist needs to have an acute awareness of factors which could be detrimental to learning since the assumption is made that the child failed to learn in the presence of adequate opportunities for learning. Physical impairments, faulty parent-child interaction, emotional disturbance, emotional deprivation, and cultural deprivation are considered to be important factors which may have a negative effect on learning. If any or a combination of these factors are present, we should be

most reluctant to accept test results as valid and prognostic of future intellectual development.

When it is possible to do so, standardized tests are administered to evaluate intelligence. These tests are composed of structured tasks administered in a clearly defined way and they provide a way for us to compare the behavior of the child being examined with that which is expected of a child at various age levels. If an adequate examination has been carried out, a mental age or intelligence quotient is obtained by summation of successful performance on test items at various age levels. The test is discontinued when all test items are failed at an age level.

The idea of adequate testing is a good one but often the child doesn't agree with this and he has his own ideas about how the time should be spent. Physical impairments, hyperactivity, distractibility, severe emotional disturbance, severe mental retardation, and lack of discipline make testing impossible at times. Observation of behavior is used in these cases and judgements are made on this basis.

Test scores are a shorthand way of transmitting information but they become quite confusing when they are interpreted literally. The explanation of the performance is often more important than the score and this should be used in talking to the parent. If a child's mental age is reported as three years, this does not mean that he does nothing more than a three year old child. A six year old child may be able to perform successfully on one or two items at the four year old level or even the four year six months old level, but the overall test performance may reflect a mental age of three years. Certainly, a significant lag in development is indicated and the results are suggestive of mental retardation. However, the test score does not state in any way that the six year old child does nothing more than a three year old child. Motor development is at a higher level in the older child and on this basis, he is capable of performing tasks which the three year old child would find very difficult and even impossible.

Dr. Edgar Doll, a psychologist at the Vineland Training School, became concerned with the inadequacy of the mental age approach in mental retardation and he developed a scale for measuring social competence. The Vineland Social Maturity Scale was developed in the early 1930's and it is widely used because it provides a way of rating the child's daily behavior. We may use the Vineland Scale alone when other testing is not possible but when possible, it is used with an intelligence test to provide a picture of how well the child utilizes his abilities.

I find the Vineland Social Maturity Scale quite useful in interviewing parents. The parent is encouraged to talk about the child's behavior and indirect questions are asked. When direct questions are asked, one usually receives an exaggerated picture of the child's capabilities. The thorough review of the child's daily behavior frequently provides additional information relating to parental attitudes, a picture of what efforts are being made to teach the child, and some idea of mistakes which are being made. Sometimes, the parent is rewarding behavior he would like to eliminate and is not aware of this self-defeating pattern. The most common findings are over-protective parental attitudes, inconsistency in parental behavior, and a lack of discipline. These factors often handicap the child and we find that he is not using the potentialities he possesses.

Testing and observation of behavior provide only part of the information needed for an adequate psychological evaluation of a mentally retarded child. A developmental history is of great value. The physician who has followed the development of the child can provide an accurate history but very few parents can do this. Information given by parents is often quite distorted and this adds confusion to a situation where test results are lacking in clarity. If I accepted the statements of parents without reservations, I would be forced to believe that many of the severely retarded children developed normally until it was time for them to walk and talk, and that most physicians believe that a child outgrows mental retardation. Unfor-

tunately, the parent may hear only what he hopes to hear and remember only what is reassuring to him.

When there is a possibility that emotional disturbance may be responsible for the behavior which is suggestive of mental retardation, an adequate medical history is essential. A sudden change in the developmental pattern of a child requires intensive investigation if it cannot be attributed to physical illness or impairment. As the American public becomes more sophisticated about emotional disturbance, we will observe an increasing tendency on the part of parents to search for emotional causes for the child's retardation, and we can expect to spend more time attempting to verify information. However, the behavior of the parents is understandable since there is reluctance to abandon hope.

When a child's condition is a diagnostic problem, the psychologist may need to make repeated observations of behavior over a period of time. If a child is so undisciplined that nobody can cope with him, it may be necessary to delay formal testing and teach the parents how to cope with the child's behavior. If physical handicaps are noted, the approach may be to have these investigated before any opinion is offered about the child's ability.

In the evaluation of a mentally retarded pre-school child, a multi-disciplinary approach is essential. Adequate communication with and cooperation between the various professions involved is of great importance if we are to offer adequate services. As our knowledge about mental retardation increases, more services will become available and there will be an increasing need to understand what role other individuals have with the child and his family.

What To Do With Sample Drugs

Several years ago when the newspapers and magazines were full of news about patients being given experimental drugs without their knowledge, I almost discarded all my samples after several patients looked at me suspiciously and asked what they were being guinea pigs for. . . Even now I hesitate to give samples to new patients, and when I do, I expressly state, "This is a *free* sample of a drug I have used for years that I happen to have in the office."—Andrew S. Markovits, M. D., in *Physician's Management*, 4: 10, (Oct.) 1964.

"Nothing Must Interfere With Our Research Efforts"

The Food and Drug Administration has a job to do and it is doing it well. It must not compromise on safety or fraud. But it must realistically face up to a greater responsibility of encouraging potentially new useful compounds with the same intensity it would seek to discard new harmless and ineffective compounds. Nothing must interfere with our research efforts. In this task the FDA must call upon the assistance of the university scientist, because both possess common long-term goals, both have skills to share, and the talent is too scarce to waste and the problems are too important to work apart. I am confident the leadership is equal to the task and that it will respond.—L. T. Coggeshall, M. D., in *Clinical Research*, 22: 3, (Oct.) 1964.

Drugs And The Changing Causes of Death

Man's progress in the field of medicine over the last half century has been phenomenal, and the pharmaceutical industry is proud of the part that it has played. It is only necessary to reflect on the significant changes that have come about in the relative position of the leading causes of death at the beginning of that period. Accidents were twenty-eighth on the list of causes of death and now are fourth. Accidents today constitute the leading cause of death among children five to fifteen years of age, whereas rheumatic fever occupied this position fifteen or twenty years ago. Tuberculosis, once "the captain of the men of death," is now seventeenth on the list and will go lower.—Alfred E. Driscoll, President, Warner-Lambert Pharmaceutical Company, in *New England Journal of Medicine*, 270: 6, (Feb. 6,) 1964.

Report Of A Clinical Evaluation

Extended Action Quinidine Sulfate

F. Bernard Schultz, M. D., F. A. C. C.

As early as 1749, Senac reportedly employed cinchona to treat palpitations. Quinidine, an optical isomer of quinine, was isolated and given its present name by Pasteur in 1853. Little was heard of this use of the cinchona alkaloids until Wekebach in 1914 reported on the use of quinine in the treatment of cardiac arrhythmias. Frey, in 1918, compared cinchona, quinine, and quinidine for the treatment of arrhythmias and found quinidine the most effective. Early enthusiasm for quinidine was soon diminished by reports of toxicity.

Today, we find ourselves in an era of more enlightened therapeutics, and quinidine, despite occasional reports of toxicity, has assumed its place as a drug of choice in the management of many auricular and ventricular arrhythmias.

Since the most frequently used salts of quinidine are rapidly absorbed and metabolized, several doses a day may be required to maintain suitable blood levels. This fact has prompted the introduction of a number of sustained release quinidine preparations. Only recently, however, has quinidine sulfate, the most commonly used quinidine salt, became available in a sustained release form.*

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*Quinidex Extentabs®, A. H. Robins Company, Inc., Richmond, Virginia.

The purpose of this paper is to report the results of a clinical assessment of Quinidex Extentabs®.

MATERIAL AND METHODS

Each Quinidex Extentab® contains 300 mg (5 grains) quinidine sulfate, USP. Of this amount, 100 mg are released in the stomach and are available for immediate absorption. The remaining 200 mg are designed for slower release as the tablet moves along the intestinal tract. Thus, the quinidine lost through metabolism and excretion is replaced through the continuous release of additional quinidine sulfate from the Extentab®.

The 21 patients treated in this clinical evaluation were selected from private practice and included both hospitalized patients and outpatients. Although the ages ranged from 20 to 87 years, the majority were in the fifth and sixth decades. Twelve were males and nine were females. On the initial examination, auricular fibrillation was diagnosed in ten cases. Some of these patients also had premature ventricular contractions and one had auricular flutter. Paroxysmal auricular tachycardia was diagnosed in six cases and miscellaneous arrhythmias in three. The drug was administered prophylactically in two cases of acute myocardial infarction.

The usual dose for patients with acute fibrillation was one Extentab® every eight hours followed by a reduction to one Extentab® every 12 hours. The dosage for patients with chronic auricular fibrillation was one Extentab® every 12 hours. Three of the patients with auricular fibrillation had been converted to normal sinus rhythm with quinidine sulfate, USP, and the Extentabs® were employed for maintenance therapy. Patients

who were in acute congestive heart failure and had not been digitalized, were digitalized over a 48 hour period and diuresis was enhanced with an oral diuretic. Eight patients received digitalis concurrently with Quinidex Extentabs®.

Electrocardiograms were obtained on all patients initially and were repeated at intervals during the course of therapy. Patients have been continued on the drug for up to 21 weeks and at this writing, 15 are continuing to take Quinidex Extentabs® with satisfactory results.

Since quinidine is recognized as a potent drug with inherent toxicity as well as interaction with other drugs administered concurrently, such as digitalis, each patient was carefully observed for signs of toxicity including allergy or idiosyncrasy, febrile reactions, skin eruptions, and cinchonism. The electrocardiograms were examined for cardiotoxic effects such as ventricular extrasystoles, an increase in width of the QRS complex, complex A-V block or ventricular tachycardia.

As a further evaluation of the extended action properties of Quinidex Extentabs®, serum quinidine levels were measured in eight cases. In the determination of our Serum levels, the following procedure was followed.* Quinidex Extentab® was administered at 6:00 a.m. and blood samples were drawn at two hour intervals beginning at 8:00 a.m. through 4:00 p.m. The plasma quinidine levels were measured fluorometrically, using a chloroform extraction method. The fluorescence in dilute sulfuric acid was measured on a Beckman DK2 ratio recording spectrophotometer and rechecked on a Beckman DU spectrophotometer. Samples were run in duplicate and the average taken.

The clinical effects of quinidine therapy were rated according to the following criteria:

TABLE 1.

CLINICAL RESPONSE TO QUINIDEX EXTENTABS®

Indication	Pts.	Therapeutic Response			
		Exc.	Good	Fair	None
Auricular fibrillation	10	7	2	1	--
Auricular tachycardia	6	6	--	--	--
Miscellaneous	3	2	--	--	1
Prophylactically after myocardial infarction	2	1	1	--	--
TOTAL	21	16	3	1	1

Excellent—conversion to normal sinus rhythm with no side effects.

Good—maintenance of normal cardiac rhythm with only occasional aberrations and no clinical side effects.

Fair—slight clinical or electrocardiographic evidence of improvement.

None—no apparent benefit from drug.

RESULTS

Therapeutic response. The clinical response to Quinidex Extentabs® is summarized in Table 1. Over-all, there were 19 excellent or good responses, one fair response and one therapeutic failure. Of particular interest are the excellent results obtained in patients with auricular fibrillation, three of whom were on quinidine sulfate, USP, prior to the study and were switched to Quinidex Extentabs® for continued therapy. Five of the 10 patients were started on Quinidex Extentabs® at a dosage of one Extentab® q. 8 h. followed by maintenance doses of one Extentab® q. 12 h., and the other five patients were started on a dose of one Extentab® q. 12 h.

Serum quinidine levels, measured in eight cases showed some variation from patient to patient. However, levels were adequate in these cases to produce the desired clinical response on dosage of one Quinidex Extentab® b. i. d. or t. i. d.

Figure 1 shows a portion of pre-drug electrocardiograms and those taken 24 hours after initiation of Quinidex Extentab® ther-

*The plasma quinidine levels were done by Mr. W. B. Wheatley, Chief of the Lee County Hospital Laboratory.

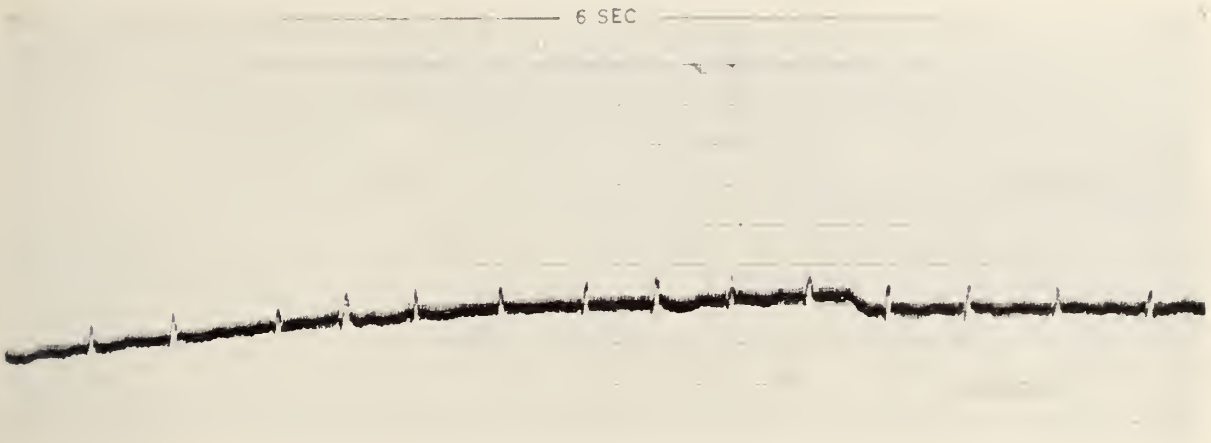


Figure 1—Patient No. 3 Before

Electrocardiograms, pre-drug and 24 hours post-drug, on two patients (No. 3 and No. 6) with auricular fibrillation. In both cases conversion to NSR occurred within 24 hours without side effects.

apy in two patients (No. 3 and No. 6) with auricular fibrillation. Patient No. 3 was given one Extentab® q. 8 h. while patient No. 6 was given one Extentab® q. 12 h. Serum quinidine levels on both these patients were compatible with the excellent clinical response observed. Both patients were also on digitalis, and normal sinus rhythm has since been maintained with a dosage of one Quinidex Extentab® b. i. d.

The one patient who was noted to have had no response to treatment with Quinidex Extentabs® had a history of auricular fibrillation and had a bigeminal rhythm when started on the medication. The response was graded on the lack of both electrocardiographic and clinical improvement one week later. He was, however, continued on Quinidex Extentabs® and when seen one month later, he was improved both clinically and by electrocardiogram.

Side Effects. One patient complained of gastric distress on a dose of one Extentab® three times a day with meals. When the dose was reduced to one Extentab® b. i. d., the nausea disappeared. Another patient who had complained of considerable gastric distress while taking quinidine sulfate, USP, tolerated Quinidex Extentabs® without any untoward effects.

Three patients died during the course of the study. Two were patients who had been given Quinidex Extentabs® prophylactically after an acute myocardial infarction. The other was a 68 year old woman who was admitted with acute congestive heart failure and auricular fibrillation. This patient died

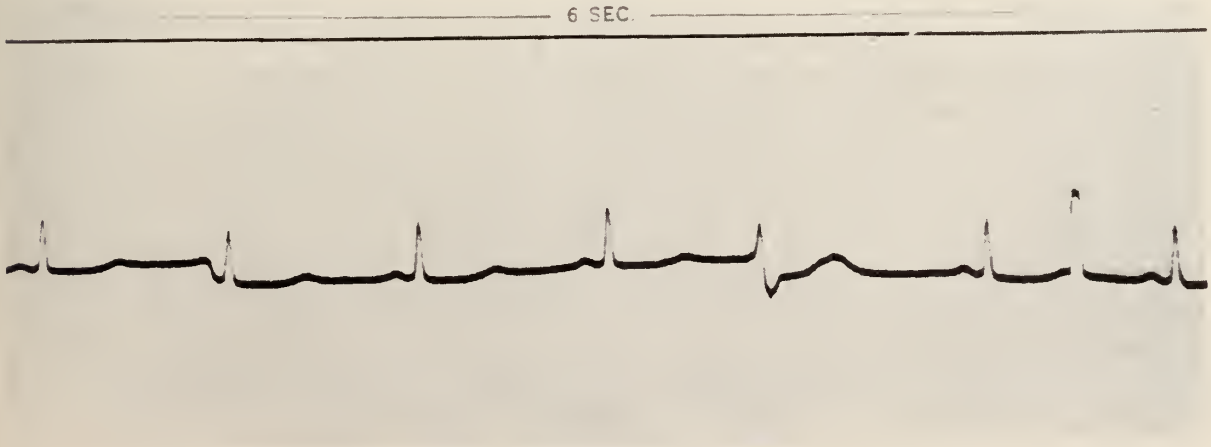


Figure 1—Patient No. 3 After

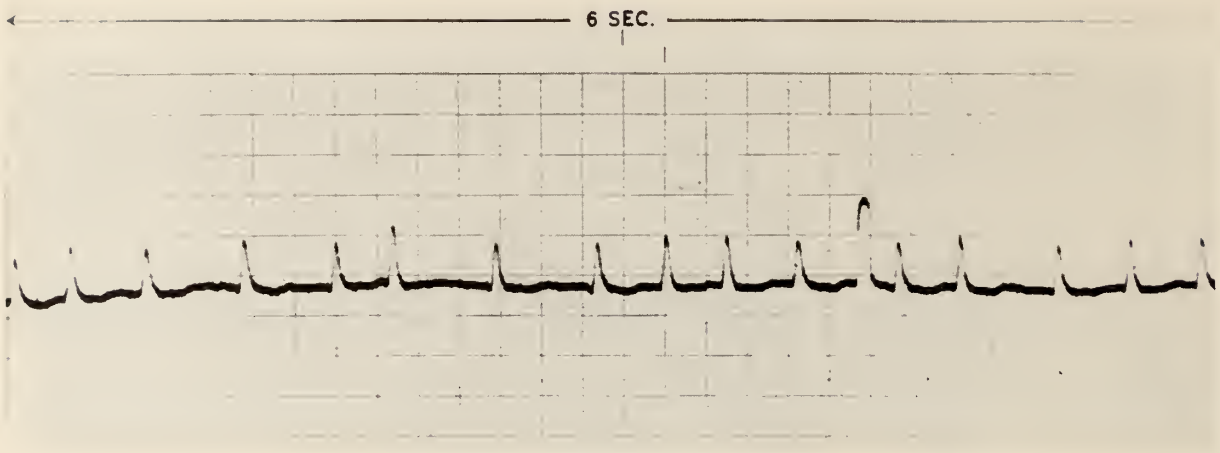


Figure 1—Patient No. 6 Before

on the sixth hospital day after showing fair response to the medication.

DISCUSSION

In general, the results obtained with Quinidex Extentabs® were favorable as determined by clinical response and, in most cases, by favorable change in the electrocardiogram. Although clinical response is obviously important, it does not always reflect the true physiological status. Patients (with premature beats and auricular fibrillation) may appear well clinically, and continue to live and function for years; however, the continued strain on the heart muscle will eventually lead to fatigue and decompensation.

In the six cases, the patients were on quinidine sulfate, USP, at the beginning of the study and were changed to Quinidex Extentabs® for maintenance therapy. These patients continued to have satisfactory clinical response. Patients, in whom Quinidex Extentabs® were used for conversion of an arrhythmia, likewise showed satisfactory results for the most part. One patient who had previously received quinidine sulfate, USP, and complained of colic and diarrhea was switched to Quinidex Extentabs®, one b. i. d. This patient maintained a normal sinus rhythm for about one month, at which time he reverted briefly to his previous abnormal rhythm. He was continued on Quinidex Extentabs® and when seen two weeks later, had a normal sinus rhythm which has now been maintained for over three months without signs of toxicity or side effects.

Since the effect of edema and azotemia may be of significance when considering

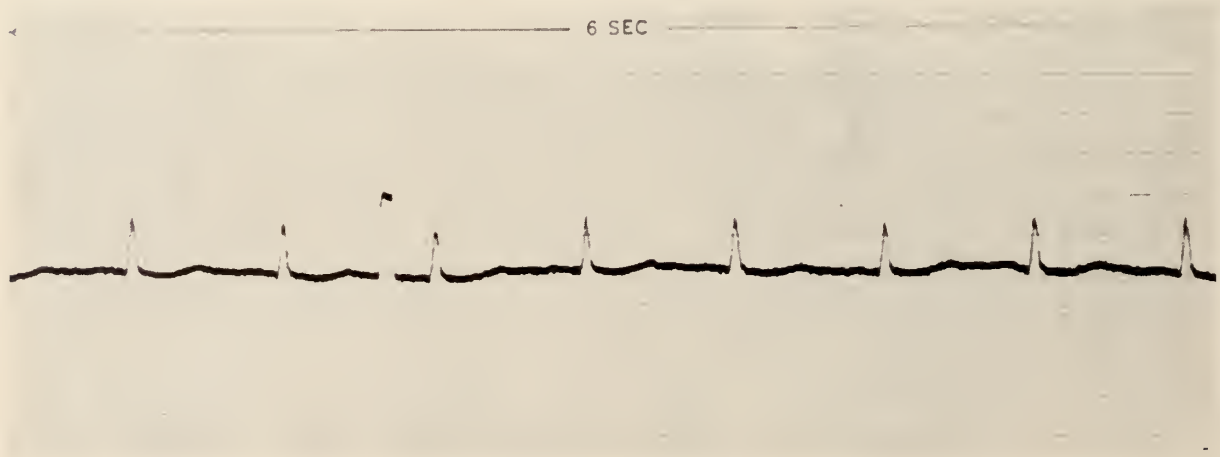


Figure 1—Patient No. 6 After

quinidine therapy, the following case may be of interest:

The patient was a 51 year old male admitted to the hospital with auricular fibrillation and acute congestive heart failure. The patient had marked generalized edema and azotemia (BUN 86, 104, 84). He was digitalized, treated with a mercurial, and then placed on an oral diuretic for continued control. Quinidex Extentabs® were administered in a dose of one q. 8 h. Normal sinus rhythm was restored within 24 hours. Serum quinidine levels on this patient were somewhat lower than the average observed in other patients, but indicated that quinidine excretion can be satisfactory even in the presence of impaired renal function. This patient continued to take Quinidex Extentabs® as an outpatient for several weeks, and repeat electrocardiograms during this period showed normal sinus rhythm with occasional premature ventricular contractions.

The presence of bundle branch block is considered by some a contraindication to the use of quinidine. Goldman,[1] however, in 1950 reported the successful conversion of auricular fibrillation to sinus rhythm in seven of nine patients with bundle branch block or intra-ventricular block. Four patients in the present series with aberrant cardiac rhythms and bundle branch block were converted to normal sinus rhythm without ill effects. The dosage administered at the time of conversion was one Extentab® q. 8 h.

Two patients were admitted to the hospital with acute myocardial infarction without evidence of shock, bundle branch block, A-V block, or aberrant cardiac rhythm. Among ominous complications of acute myocardial infarction is the development of cardiac arrhythmias such as sinus bradycardia, premature beats, auricular fibrillation, auricular or nodal tachycardia, or ventricular tachycardia. After a few days of hospitalization one of these patients began to complain that his "heart pounded" intermittently. Normal sinus rhythm was maintained under Quinidex Extentabs® therapy, but he later suffered an extension of his infarction and expired. Another patient with acute myocardial infarction was also converted from auricular tachycardia to normal sinus rhythm with Quinidex Extentabs®, but died the next day. At autopsy this patient was found to have cancer of the gall bladder with metastases to the liver and lungs and evidence of a recent posterior infarction. In spite of the fatal outcome in these two cases of myocardial infarction, Quinidex® administration was considered to be a rational prophylactic measure.

The development of cinchonism is not usually sufficient reason to terminate quinidine therapy. Mild gastrointestinal symptoms can usually be minimized if the patient takes the drug with food. During early treatment, one patient developed nausea and vomiting while taking quinidine sulfate USP. When this patient was switched to Quinidex Extentabs® no further GI symptoms were encountered.

Although digitalis slows the ventricular rate in auricular fibrillation, it does not necessarily restore normal sinus rhythm. Therefore, quinidine may be used to attempt conversion while digitalization is being maintained.[2] This regimen was employed in treating several patients in this series with satisfactory results.

SUMMARY

Twenty-one patients were treated with Quinidex Extentabs® over a period of one to four months for cardiac arrhythmias associated with hypertensive heart disease, acute congestive heart failure, rheumatic heart disease, and myocardial infarction. The therapeutic response was regarded as excellent in 16, good in three, fair in one, and negative in one.

The sustained release dosage form of quinidine, Quinidex Extentabs®, is a satisfactory and convenient method of administering quinidine sulfate.

REFERENCES

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2. Friedberg, C. K.: Diseases of the Heart, p. 365, 2nd Edition, Saunders Co., Philadelphia.

Public Health In Alabama

Sidney J. Williams, M. D., M. P. H.

Nearly a century ago that great British Statesman, Disraeli, said, "The Public Health is the foundation upon which rests the happiness of the people and the welfare of the nation. The care of the Public Health is the first duty of the statesman."

Dr. C. E. A. Winslow around 1920 defined Public Health as "The Art and Science of preventing disease, prolonging life, and promoting physical health and efficiency through organized community effort."

In discussing the past history of public health in Alabama there is of course the temptation to review the efforts of early pioneers. I shall, however, confine my remarks to the more recent past and present the following as indicative of the era:

On the fifth day of July, 1904, that distinguished Alabamian, General William Crawford Gorgas sailed from New York City with a handful of medical pioneers bound for Panama. Included in this group was a Virginian, later to become president of this Association and to be an equally distinguished Alabamian, Dr. Lloyd Noland, then only 24 years old. The story of Dr. Noland's part in cleaning up the Canal Zone and making possible the building of the Canal is an intriguing one, but on which time does not permit me to dwell.

In 1912 George Gordon Crawford, president of the Tennessee Coal, Iron and Railroad Company of Birmingham, took a trip to Panama supposedly for a vacation. Actually it was more than a vacation. It was a search for the solution to a problem.

President Crawford's Tennessee Company had not been well, financially or physically. Crawford understood this financial sickness. The greatest cause was the nearly 400 per cent turnover in the labor force, a problem which in 1912 often seemed insuperable.

Mr. Crawford sought out Dr. Noland and told him of the problem in the Tennessee Company's area. After a week of conferences between the two, Mr. Crawford asked Dr. Noland to take over the job of cleaning up the Tennessee Company's very dirty back yard.

Dr. Noland agreed to go to Birmingham and look the situation over. So in January of 1913 Mr. Frank W. Crockard, the company's vice-president took him around to see the mine and plant communities. Twenty of these villages were owned outright by the company (most of them being within a 15 or 20 mile radius of the home office in Birmingham). Conditions everywhere were just as bad as Mr. Crawford had reported. Dr. Noland found that the water supply in the villages was so polluted that in most instances it had to be condemned. Disease was rampant. Typhoid epidemics were constant occurrences. Smallpox was as common as

bad colds. Hookworm, dysentery, and enteritis were almost the rule.

In the mining towns there was no sanitary disposition of human waste. Mule dung was piled high in every mining village, attracting great hoards of flies. Stagnant water pools served as constant breeding places for mosquitoes. The air was alive with disease.

Dr. Noland found that in many cases conditions were almost as bad as they were in Panama. Certain of the little local emergency hospitals were well kept up, but many of them were both filthy and inefficient. Insanitary living conditions and inefficient medical care were therefore responsible for an increasingly vicious cycle of disease. When the workers—constantly exposed to disease—became sick, they were not given proper attention, but instead became carriers for a more rapid spread of the same disease. The result was that in 1912 the average laborer's attendance at work was only about 12 days a month.

After his survey of the situation, Dr. Noland presented his plan for a health department, including a "doctor's dream" hospital for the employees. Mr. Crawford pledged full support. With co-operation from the company assured, Dr. Noland sought an understanding with organized medicine. He arranged a meeting with Alabama's Board of Censors, which in 1913 was under the chairmanship of Dr. W. H. Sanders. At the meeting of this body Dr. Noland outlined his plans which were ambitious and daring. Dr. Noland stated that he expected to work day and night himself—and to spend three-quarters of a million dollars in the first year alone to make his plan work.

The three-quarters of a million figure shocked the Board considerably. Up until that time the entire amount spent on public health for the entire State of Alabama was only $25,000 per year. But, the Censors promised Dr. Noland the undivided support of Alabama medicine.

I shall not go into any details as to Dr. Noland's monumental success in organizing and directing the company's health department and the resultant dramatic and enduring enhancement of the state of health of the people. These facts are well known to all.

The most important aspects of our public health program today are still centered around communicable disease control through immunization and sanitation along with case finding and treatment of tuberculosis and venereal diseases and finding and treating cancer. We also have our maternal and child health program. To these have been added activities in the field of geriatrics with nursing of the chronically ill at home by the public health nurse a specific measure. Efforts in the field of mental health have been accelerated. Both the public health and economic aspects of the so-called population explosion have led us into a more intensified planned parenthood program. I find myself engaged in such a program which we hope will result in motivating those who should avail themselves of measures offered for child spacing to do so. The disgusting and alarming increase in illegitimacy in the negro with attendant public health, social, and economic problems should be studied at length.

We find ourselves also engaged in studies dealing with air pollution, with radioactive fallout, and other facets of radiological hazards. Accident prevention programs are in effect in some counties. At the state level there are, of course, other activities such as anti-stream pollution measures, medical care programs, hospital planning, and inspection services, and sanitation of shellfish and other control activities.

Now, what about the future? The activities just mentioned will certainly be expanded. We have the Sabin oral vaccine and we have reason to expect polyvalent immunizing agents, oral as well as injectable, to protect against the adeno-virus diseases. Stronger stream and air pollution controls are essential. Population control and the illegitimacy problems have been referred to.

We can expect good preventive measures to forestall crippling effects of such conditions as pulmonary emphysema and other respiratory diseases. Papanicolaou has

shown us the way to early detection of cancer of the cervix. His technique is employed now in our maternity clinics. It is not unreasonable to hope for practical elimination of this form of cancer as a killer. Even before we have more knowledge of the causes of cancer, we can expect further improvements in early detection and treatment to lower the death rates. But preventable disease measures, especially communicable disease control, will be our chief concern for as far ahead as I can see.

The fire prevention people tell us that it takes three things to make a fire: fuel, air, and heat. Likewise, it takes three things to make an epidemic: people, lack of control measures, and the germ.

There are three broad approaches to controlling communicable diseases in our world today. The first is immunization (and the list of diseases which we in our country primarily control through immunization is of course well known to all of us). The second main approach is sanitation, a rather broad field covering two main types of sanitation. One kind is the sanitation of that which goes into the mouth and the proper disposal of that which comes out, and includes sanitation of water, sewage and food, and proper disposal of body waste. The other method of sanitation is to control or eliminate those vectors of disease such as insects and rodents which are capable of spreading disease from animal or human reservoirs. A third category of the approach to communicable disease is by use of chemotherapeutic and antibiotic agents. This applies to only a limited number of the communicable diseases as primary health means of control, but nevertheless, is important. (In these diseases, you have to find the ill person and then treat him to render him unable to give the infection to others.)

Now, we have a good tool in all three of these fields; we have good knowledge of sanitation. We have good immunizations and we have reasonably good antibiotics, and yet, these diseases are still with us. To document this, let us examine some statistics at the national level for the year 1961 because it is the last year we have been able to get complete statistics for both cases and deaths. I am using National instead of State figures because I think they are more meaningful in the long run. *Diphtheria*: over 600 cases with 68 deaths. *Whooping cough*: over 11,000 cases with 76 deaths. *Tetanus*: 379 cases with 242 deaths. If anyone thinks that tetanus is not a threat, look at the death rate for that year—64 per cent. *Poliomyelitis*: last year over 1,300 cases with 90 deaths. This was considerably reduced last year by the oral polio vaccine.

Let's take the field of diseases of sanitation. Over 8,000 cases of *Salmonella* infection were reported in this country in 1961 with 64 deaths, and we know that this is a rather poorly recognized and reported disease, and there were probably several times this in actual numbers. *Typhoid fever*: 814 cases with 17 deaths. Many people think that there is no longer any typhoid fever in this country, but they are grossly mistaken. *Shigella* infections: over 12,000 cases. *Infectious Hepatitis* that year, over 72,000 reported infections (and probably several times this unreported) with almost 1,000 deaths.

We thought that when penicillin came out that the venereal diseases were licked. Yet in 1961 there were in the United States over 20,000 cases of infectious syphilis and an equal number of early latent; we had a quarter million cases of gonorrhea reported, which means that actually there were about a million cases. There is much concern in that about one half of the reported venereal disease cases are in teenagers. Instead of being licked, it appears that the trend is going against us.

Take tuberculosis. The trend is going against us. In 1961 there were almost 50,000 new cases in the nation with about 10,000 deaths. Last year for the first time after falling steadily for some decades, tuberculosis started increasing. Last year for the first year in a long time in the nation, and for the second straight year in Alabama, the case rate rose. We have noted with alarm the increasing resistance of the tubercle bacillus to our antibiotic and chemotherapeutic agents.

My good friend, Dr. Joe Molner, writing in his syndicated column quotes from a Michigan Tuberculosis report: "Dreams of conquest of this lumbering giant of human diseases (tuberculosis) following discovery of drugs in the early fifties are dimming. The facts of life are that tuberculosis is here to stay for a long time. Tuberculosis has settled into an obstinate pattern of resistance to known methods of detection and treatment."

Dr. Molner estimates that there were between 75,000 and 100,000 new cases in the United States last year.

It is with dismay that we learn that the federal budget for the coming fiscal year calls for no funds whatsoever for tuberculosis control. If this budget stands as is, Alabama will find its tuberculosis funds cut by $70,000 effective July 1 of **this year.**

Now, some people actually feel that we are losing ground in other of these diseases. Why should we be losing ground? Well, in part, because we do not have enough public health workers. I think this is a very real thing; all of us in the field of public health feel the need for more workers, but this is not all of the explanation. Part of the problem in so far as it falls upon us in the health field, this means you and of us, falls on our attitude, perspective and approach.

Instead of using and causing the community to use a real preventive approach we too frequently have used a symptomatic one —we have sprayed mosquitoes and their breeding places, when we should have **prevented** the places in the first place. Children have to be treated for diphtheria or even die when immunization would have prevented the disease. It is a matter of fact that 25 per cent and more of the young children in many parts of Alabama have not been given even one dose of an immunizing agent against any of those diseases for which we have good immunizing agents. I could go on and on. We know that one third of the people in the nation live in slums. These slums account for 50 per cent of communicable diseases, 55 per cent of the juvenile delinquency, use 45 per cent of the total funds spent for public services, and yet pay only six per cent of total tax revenues. We countenance these conditions, as we do open garbage dumps, instead of preventing them.

We are witnessing the transition from a rural to an urban civilization and people are living closer together as the population increases. Good n e i g h b o r h o o d s become crowded and then become mediocre, mediocre ones go down and finally become slums. People are mixing more and more, rural schools are consolidated, people are traveling more and faster. Thus a disease outbreak starting, say in Asia, can be introduced into various parts of this country simultaneously, and in a very short time we have an epidemic, widespread, on our hands. Remember the Asian Influenza epidemic?

We know that we are in the yellow fever receptive area, yet, only now is some effort at eradicating the Aedes Egypti mosquito beginning to receive some serious attention.

In South America last year I had the opportunity to discuss some problems with an Argentine entomologist who was surprised to learn that we have the Anopheles mosquito still with us.

Are communicable diseases licked? Hardly! Yet some people seem to think that this is true.

I know of no germ that has ever been identified as causing a communicable disease which is not still existent somewhere on the face of this earth, with the possible exception of the more severe form of yellow fever. Plague and all other germs are somewhere causing communicable diseases, and it will take only a breakdown in control measures and the disease will be back with us.

Dr. Edward J. Stieglitz in 1945 said: "Health is not an inalienable right. It is a privilege. Privileges invariably entail equivalent responsibilities. It is so easy to accept privileges that, before long, mankind takes them for granted and claims them for inherent rights. Nature grants few rights, preferring to demand that privileges be earned. Health, like freedom and peace, continues only as we exert ourselves wisely to maintain it."



FLEDGLING ALAPAC TRIES ITS WINGS

A sufficient time has elapsed to permit a preliminary analysis of the role played by ALAPAC in the recent Congressional elections. The final record probably will show that this new venture into the field of politics was more successful than anyone expected it to be and less successful than it could have been.

A major flaw developed almost from the first, when it was discovered that the ALAPAC Board possessed altogether too little knowledge of doctor attitudes toward the candidates for Congress. In other words, the ranks of the Medical Association of the State of Alabama were far from united on any one candidate.

Another major flaw was failure of ALAPAC to organize at the grass roots level. In future elections it can be anticipated that every county medical society and every auxiliary will have workers trained to exert spirited effort on behalf of the candidate who carries Medicine's banner highest.

On the positive side, an accounting of ALAPAC's performance in 1964 would show that it had an intimate knowledge of every candidate's position on those issues of vital concern to Medicine, that its information on the vote-getting strength of the several candidates was accurate, that it crossed party lines to lend support to the candidate of its studied selection, and that, although it backed some who failed to win, its over all batting average was good.

It is well that ALAPAC's first test came in an election in which only two candidates were in a "doubtful" category. In future races, particularly those on the state level, the lessons learned in 1964 will pay rich dividends.

ALAPAC has also found that it can participate in local legislative races and not be subject to the Hatch Act which is a Federal Law. We must be more cautious and support both sides if need be to insure Medicine's bipartisan position. If we are too rabidly opposed to one candidate or too anxious to support another, then when the smoke clears away, we will be regretting our haste or excessive enthusiasm, whichever the case may be.

WE NEED YOUR HELP

Elsewhere in this issue there appears a questionnaire of great importance to this and other state medical journals.

Every member-reader is asked to take a few minutes to complete the questionnaire and mail it to us at the earliest possible moment.

Your critical comments and constructive criticisms are urgently needed if your medical journal is to perform a worthwhile job for the Medical Association of the State of Alabama.

MEDICINE'S LEADERSHIP POINTS THE WAY

The new year is just a few days old, but there already are signs that 1965 will be an eventful year for medicine.

On the national scene the Congress almost certainly will come to grips with medicare and many other bills which will bear heavily on the future of doctors throughout the land.

And closer to home, the Alabama Legislature will be called upon to make momentous decisions in such matters as public health, mental health, and expanded benefits for the aging indigent.

If, in the past, doctors have been prone to "attend to their knitting" and steer clear of things political, the same cannot be said today. Medicine has learned the hard way that politics—good, bad, or indifferent—is merely another way of saying government; and therein lies our fate.

Dr. Donovan Ward, president of the American Medical Association, spoke with courage and determination when he pledged to continue the fight against passage of the medicare bill. To paraphrase him loosely, "If we were right when we began this fight, then we are right today."

To be sure, there are some in the medical profession who trumpet doom. "We are lost," they moan. "Why fight any longer?"

But were these harbingers of defeat ever really in the fight? More likely, they have been sitting on the sidelines from the beginning, saving their energies and their voices until the smoke of battle descended on the stalwarts in the forefront of the fight.

If America is truly the land of the brave and the home of the free, then every doctor can take pride in Medicine's leadership. "Our heads are bloody but unbowed," Dr. Ward asserts. "We shall fight on."

Can any physician, believing in the rightness of his cause, do less?

HOVERING GOVERNMENT

Your editorial, "Balancing the Books" (Presbyterian Survey, September, 1964, p. 5), seems to defend the welfare state in general and the so-called Medicare Bill in particular. The implication is that anyone who does not want the federal government hovering over him from cradle to grave, supplying his every need with taxpayer's money, is callous to human need. I resent the gallons of crocodile tears being shed over the 18 million citizens over 65. Many of us are well; many have some private hospitalization plan; and some even have children able and willing to care for their parents. The sick who are unable to pay for hospital care should be cared for, of course. The question is not **whether,** but **how** and **by whom.** I do not blame the young man for not wanting "to pay for all those other people," when so many of them are more able to pay for themselves than he is.

—Mrs. Sally B. Hopkins
Demopolis, Alabama

Mid-South Assembly

The 76th annual meeting of the Mid-South Postgraduate Medical Assembly will be held at the Peabody Hotel, Memphis, Tennessee, February 9-12, 1965.



"Now you'll be able to go home and sleep on it."
Westchester (N. Y.) Medical Bulletin



Leader Of Aging Citizens Looks At Kerr-Mills

TO: The Medical Association of the State of Alabama

FROM: Rubin Hanan, President of the Alabama League of Aging Citizens; Co-Chairman of the Joint Legislative Committee; Consultant on Aging to the Secretary of Health, Education and Welfare, Washington, D. C.; Chairman of the State Commission on Aging

Dear Friends,

All of us, the medical profession and the old age organizations in Alabama want to make sure proper medical care is received by older people.

As they reach their sunset years, the security, health, and happiness of Alabama's senior citizens should be on our conscience. Some senior citizens in this State are in great need of medical, hospital, nursing care and drug assistance.

We, as free and God-fearing people, must see to it that all older citizens enjoy their remaining days in peace, painless and dignified, not as wards of the Governments or Charity, but as free citizens able to live their lives in gracious fulfillment.

A most cherished part of our American tradition has been the public image of the family physician. Much has been written and said with affection about the wise old family doctor who spent so much time and effort in helping his patients overcome their personal difficulties as well as their medical problems. Because of his nobility of purpose, his self-sacrificing devotion, and his understanding, he was regarded as a father substitute and was often closer to the people than their minister, priest, or rabbi. He gave unsparingly of his affection, his time, his energy, his professional knowledge, and his professional skills.

We need our physicians today to combine their knowledge of medicine and their keen

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Editor's Note: This article is published as a means of informing the medical profession of views held by that group benefitted most by the Kerr-Mills law and who, incidentally, are chief proponents of the proposed Medicare bill. Views expressed herein are those of Mr. Hanan. The Journal will welcome letters of rebuttal from members of the Association and will endeavor to print as many in the February issue as space permits.

understanding of people with a warm and sympathetic personality to stimulate the complete confidence of their patients, and they must have utter disregard for personal comfort or for financial remuneration.

After four years of operation, the Kerr-Mills medical assistance for the aged or better known as MAA Program or Opportunity Health Program has proved in the State of Alabama to be at best an ineffective and piecemeal approach to the health problems of Alabama's 285,000 senior citizens, simply because of the financial inability of the State to cash in on all of the provisions of the Act.

Since this Act took effect on October 1, 1960, the League closely observed its operation in the State and has periodically evaluated the program.

(1) MAA Program, with which the Medical Association and old age groups are concerned, was never expected by itself to provide the **sole avenue** for financing medical or hospital or nursing care for the aged.

(2) Today, the OAA or MAA Programs after four years of operations still suffers from these major defects:

A. Stringent eligibility tests and responsible relative provisions have severely limited participation of the aged in this program.

B. The duration, levels and types of benefits vary more in Alabama than in high per capita income states.

C. The distribution of Federal matching funds under MAA or OAA has been grossly disproportionate, with a few wealthy states, best able to finance their phase of the program, getting a larger share of funds.

D. The Welfare aspects of the Kerr-Mills MAA program, include cumbersome investigations of eligibility.

E. Kerr-Mills MAA or OAA programs depend too heavily on the already burdened budgets of the low income states. As a result thousands of the state's senior citizens find qualifying so humiliating that many do not apply for the assistance to which they are entitled.

The Subcommittee on Health of the State Commission on Aging, under the leadership of two outstanding doctors, Dr. Ira L. Myers and Dr. Gilbert F. Douglas, Sr., is studying needs in this area. Some of the topics of great concern are in relation to additional hospitals, nursing homes, nurses and health clinics, visiting nurses programs, and the establishment of homemaker and home aide services.

The Kerr-Mills Act cannot, of itself, solve the problem that confronts our old people and it is most persistent and frightening. We need new ways of assuring the old people economic access of adequate medical care on a decent, self-respecting basis.

WHAT IS NEEDED TODAY?

1. Medical fees based on ability of the patient to pay and at a level which will encourage the continued development of insurance and pre-payment plans at reduced premiums.
2. Provisions for more clinical or office visits than hospitalization care.
3. Home care services of all kinds, and home nursing services.
4. Consideration of legislation requiring that all pre-paid hospital and medical insurance policies, after the policy has been in force for 24 consecutive months, be non-cancellable.
5. State Legislation to take advantage of Federal funds provided by the Kerr-Mills Act.
6. Development of the philosophy of community, mental health clinics in every major city.
7. Better personal relationship with patients to continue the care and understanding of the financial problems of the individual.
8. State should liberalize both benefits and eligibility requirements for Kerr-Mills assistance.

Mental Health Activities In The South, 1964

Prepared as a service of the

SOUTHERN REGIONAL EDUCATION BOARD'S
Program in Mental Health Training and Research

130 Sixth Street, N.W., Atlanta, Ga.

DELAWARE

Legislation passed by the General Assembly and signed by Governor Elbert N. Carvel creates a state department of mental health . . . Legislation stipulates that Commissioner, who will have charge of all mental health facilities, including the mental hygiene clinics, shall be psychiatrist who is certified by the American Board of Psychiatry and Neurology, and further qualified by broad training and experience in the administration of hospital and community programs of prevention and early treatment . . . Cost of operating the mental health program will be increased from $4,772,100 to $5,348,690.

GEORGIA

Legislature concentrates efforts on education, with little activity in mental health field . . . Funds appropriated for new hospital for mentally retarded children . . . Program established for mentally retarded, educable, blind children, to be administered by State Board of Education . . . Revision of state's health codes completed . . . No action taken on state joining Interstate Compact on Mental Health.

KENTUCKY

Appropriation for mental health falls $5 million short of budget requests . . . State's new mental health facility scheduled to open July 1 can be only partially used due to lack of funds; grand jury calls situation "distressing" and urges funds be provided for full activation . . . Enabling act authorizes establishment of regional community mental health services programs . . . New act allows retarded to be admitted to state hospitals on same basis as mentally ill, without court commitment procedures.

LOUISIANA

Greatly expanded programs in mental health and mental retardation, including extensive out-patient facilities, are envisioned in a legislative package approved by the Louisiana Legislature during its 1964 session . . . Major reorganization of the State Department of Hospitals to set up divisions of mental health and mental retardation under the department's jurisdiction is vital to program . . . Two new commissions are also created in the reorganization package—a Planning Commission and a Construction Commission . . . Future plans call for eight regional mental health treatment centers. The Legislature created a Joint Legislative Committeee to aid in setting up a master plan to expand the state's program of mental health and submit its findings to the Legislature at its 1965 fiscal session . . . A new program for diagnosing and combatting phenylketonuria in children was authorized . . . Approval given to a statewide program of special classes for exceptional children.

MARYLAND

Funds appropriated for land acquisition and planning of new community mental

health centers contingent upon receipt of matching federal funds . . . State mental health director declares centers should save millions in hospital care . . . $50,000 authorized for planning center for mentally retarded . . . Legislation enacted on confinement of alcoholics . . . Mental Health budget increased $1.7 million over current fiscal year, with an additional $2.4 million for capital improvements and increased staff.

MISSISSIPPI

Increased appropriations for Mississippi's mental institutions and designation of the state department of education to accept and disburse federal funds for training teachers of mentally retarded children were the major measures in that field approved at the 1964 regular session of the Legislature . . . The 1964-66 biennium budget for mental institutions was increased nearly 5 per cent or $600,500 . . . New allocation was $25,000 for the Hospital Reimbursement Commission which seeks collections from patients, or their families financially able to pay for treatment . . . $1,167,500 approved for additions to mental institutions in Mississippi . . . Proposal defeated to create Mississippi Commission on Mental Retardation.

SOUTH CAROLINA

Decentralization bill establishes State Department of Mental Health with Dr. William S. Hall as Commissioner, and five deputy commissioners . . . Revolving loan fund enables mental health department to borrow for construction and renovation, with patient fees to go toward interest and retirement of loans . . . Operating budget appropriations increased $1 million . . . New psychiatric institute begins operation . . . Work progresses on $2.5 million retarded children's habilitation center near Charleston.

VIRGINIA

Budget increase of 8.6 per cent over current amounts will provide "modest increases and expansions of existing activities" in state mental hospital and clinic system . . . Laws modernized on detention, treatment and release of mentally ill . . . Study Commission examining entire concept of care and treatment of mental patients . . . New intensive treatment center for emotionally disturbed children to receive $600,000 per year; recruiting and training staff has delayed full operation . . . $6 million appropriated for new building and renovation . . . Studies ordered of services provided for the mentally retarded and of state facilities for treating and rehabilitating alcoholics.

WEST VIRGINIA

Budget requests which would have doubled state's mental health funds denied by legislature . . . Mental health director calls attention to serious problems resulting from overcrowded conditions . . . Salary increases for mental institution employees denied because of insufficient revenues . . . Alcoholic treatment division seeks federal grant for research and education.



The doctor informed me I've got to get more rest, so I'm afraid I'm going to have to let one of you girls go.

Nebraska State Medical Journal

around the state



Dr. L. R. Murphree, second from left, accepts a certificate of recognition from Dr. E. W. Stephenson, left. Dr. Murphree retired after thirty-two years as secretary of the Morgan County Medical Society. Others in the picture are: Dr. Sidney Chenault, second from right, chairman of the Morgan County Board of Health; and Dr. John S. Hamilton, new president of the society.



State Health Officer, Dr. Ira L. Myers, officially dedicated the new Barbour County Nursing Home at ceremonies in Eufaula on December 2. In the picture above he is shown making the dedication speech with other participants in the program on his left.



Speakers at the Anniston Medical and Surgical Seminars, held December 9, are shown above. They are, left to right, Dr. Elbert P. Tuttle, Jr.; Dr. L. H. Kwong; Dr. G. G. Woodruff, Jr.; Dr. Warren G. Sarrell; Dr. D. J. Judge; Dr. Thomas R. Marshall; Dr. Malcolm I. Lindsey, Jr.; Dr. Sherman C. Raffel; and Dr. J. Garber Galbraith.

Cross sections of the large crowd which attended are shown in the bottom photo.



Dignitaries attending the Houston County Medical Society's annual meeting November 20 included (left to right): Dr. Harmon Stokes, district vice president of the Medical Association of the State of Alabama; Dr. E. B. Glenn, president; Dr. David Hume, of Richmond, Virginia, principal speaker; and Dr. Ben Byrd, president of the Houston County Medical Society.



More than 200 doctors and their wives assembled at Selma on December 10 for the Symposium sponsored by the Dallas County Medical Society and the Black Belt Chapter of the Alabama Academy of General Practice. Shown above is a section of the luncheon participants.



Dr. John Seddon, of Liverpool, England, discusses Medical Matters with Dr. Robert M. Combs at the recent Selma Symposium.



Fellowship at the Selma Symposium is enjoyed by: (left to right) Dr. Jack Pilkington; Mrs. Joyce Fisher; Dr. George Constant; and Dr. M. C. Holcomb.



Dr. D. C. Overstreet served as program chairman for the Selma Medical and Surgical Symposium, held Thursday, December 10. Several hundred doctors and their wives attended the meeting, sponsored by Lederle Laboratories.



Senator James Clark of Barbour discusses his county's new nursing home with Rep. Sims Thomas and State Health Officer, Dr. Ira L. Myers.

Officers Elected

The section on Otolaryngology of the Southern Medical Association, at its recent meeting in Memphis, Tenn., elected the following officers for 1965:

Chairman: J. Mathew Robison, M. D., Houston, Texas; chairman-elect: Sam H. Sanders, M. D., Memphis; vice-chairman: Frederick R. Guilford, M. D., Houston, Texas and Secretary: Neil Callahan, M. D., Portsmouth, Va.

Papers are now being accepted up to May 15, 1965 for consideration for presentation at the next annual meeting of the Southern Medical Association which will be held in Houston, Texas, November 1-4, 1965. For further information communicate with the Secretary of The Section on Otolaryngology, Neil Callahan, M. D., Doctors Court, 500 Rodman Avenue, Portsmouth, Va. 23707

Medicolegal Symposium Set For March 11-13

CHICAGO—The American Medical Association and the American Bar Association have joined forces to sponsor the 1965 National Medicolegal Symposium on March 11-13 at the Dunes Hotel in Las Vegas.

The meeting will provide the physician with an excellent educational opportunity on an important part of his professional life. Some 1,200 physicians and attorneys are expected to attend.

The biennial Medicolegal Symposium, sponsored solely by the AMA in the past, was considered to be the outstanding meeting of its kind. Participation by the ABA promises an even more informative program.

Robert B. Throckmorton, AMA general counsel, said topics to be covered include the common goals and ideals of law and medicine, the medical witness, current litigation and tax problems. Trial vignettes will be used to dramatize courtroom situations.

Registration fee for the symposium will be $25.

Advance registration cards may be obtained by writing to Mr. Robert B. Throckmorton, general counsel, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Dr. Kampmeier Heads Southern Medical Association

R. H. Kampmeier, M. D., Nashville, Tenn., was installed as president of the Southern Medical Association at the recent annual meeting held in Memphis, Tenn. He will serve until November 1965.

Other officers are: J. Garber Galbraith, M. D., Birmingham, Ala., president-elect; Guy T. Vise, M. D., Meridian, Miss., first vice-president; and Harwell Wilson, M. D., Memphis, Tenn., second vice-president.

Fundamental Programming

The Doctor In Civil Defense

By JAMES H. KELLEY

Civil Defense planning concepts would be rather incomplete without reliance substantially upon the complete utilization of all available medical resources, particularly every doctor, all medical professional personnel, and all stockpiles and inventories of drugs, supplies and equipment. Likewise, to operate during any Civil Defense type emergency, doctors would be handicapped severely in their intended efforts to assist a suffering people except through the Civil Defense organization, and acting as an integral part thereof.

Fundamental programming to combat and overcome the effects of extreme natural and nuclear disasters, by key Civil Defense authorities, is reflected in the Basis Alabama Emergency Operational Plan prepared by the Civil Defense Department of Alabama. The value of the Health Services in emergency planning, and operations, here in Alabama, according to Civil Defense authorities, has been considered most significant, and having a high degree of priority.

The Alabama Emergency Operational Plan, developed by the Civil Defense Department of Alabama, and representing the Alabama area of responsibility and plan of operations, designates an entire Annex therein to the health concept entitled: "HEALTH SERVICES, ANNEX 7". Paragraph I, of Annex 7, is quoted, as follows:

"The mission of Health Services is to provide:

1. Medical care for civilian casualties and non-casualties in target and reception areas.
2. Health protection service in the form of sanitation and preventive and remedial measures to counteract biological, chemical and radiological effects.
3. Mortuary service."

Therefore, the foregoing points out there are three distinct primary responsibilities incorporated in the Civil Defense Health Services, namely: Medical Care, Health Protection and Mortuary. Providing these important services during any type emergency would require participation by every doctor within the given disaster area, with the possibility that additional doctors, along with extra professional personnel, might necessarily have to be brought into the area. Should the disaster area embrace the entire State of Alabama, or the nation, then every doctor would be called upon for all-out professional services on an emergency basis, along with all other medical professional personnel.

While the Alabama Emergency Operational Plan provides the state echelon with guidance and much detailed operational planning in the area of Health Services, a similar plan has been, or will be, developed for every county, and to include every municipality, within the State of Alabama. At the county level the Health Services Officer usually is the County Health Officer, and the Health Services organizational staff includes every doctor within the given county. The county or municipal plan is patterned after the State plan in order to provide properly coordinated services in the areas of emergency Medical Care, Health Protection and Mortuary. With the Civil Defense governmental authority, and the professional technique, the County Health Officer is responsible for the organization and direction of the functions of the Health Services within the county Civil Defense operational concept.

Mr. Kelley is chief of the Division of Plans and Operations and Survival Planning Advisor of the Civil Defense Department of the State of Alabama.

The State Health Officer is the key figure and is at the head of the Health Services within the state level of Civil Defense organization. Under his guidance and authority are Chiefs for the Medical Care Division, the Health Protection Division and the Mortuary Division, each of whom have developed, or will develop, the necessary minimum operating staff, together with sufficient reserve personnel to provide state level Health Services as may be required by any emergency.

The doctor, who is dedicated to the relief of a suffering humanity, within the Health Services Annex of the State and Local Emergency Operational Plans, has his work-load well outlined, designated and assigned. The plan was developed by, and with the counsel of, doctors and other medical professional authorities in cooperation with planning authorities in the Civil Defense Department of Alabama. The late Dr. D. G. Gill was the first Health Services Officer within the Alabama Civil Defense Emergency Operational Plan, and the office now is administered by Dr. Ira L. Myers, State Health Officer.

Some of the detailed functions outlined in the Alabama Emergency Operational Plan, and likewise contained, in substance, in the County or Municipal plan, and by which every doctor in Alabama may refer for guidance in planning emergency functions during any Civil Defense type emergency, are quoted, as follows:

The Health Services of the Civil Defense Program of the State of Alabama has the following functions:

1. Provide medical care service.
   a. Emergency First Aid.
   b. First Aid stations for completing First Aid care at fixed locations.
   c. Emergency Hospital Stations: Small hospitals of limited bed capacity and improvised hospitals, treatment of casualties and non-casualties on a short range basis before transferral to larger establishments.
   d. Hospital care: Designation of existing hospitals and planning for Civil Defense Emergency Hospitals (39 in Alabama, each complete with 200 cots for emergency beds) for the long range care of casualty and non-casualty patients.
   e. Medical Care Evacuation: Planning suitable routes, when deemed necessary, for evacuation of patients in cooperation with other Civil Defense services.
   f. Blood Program: Planning and supervising a program for adequate supplies of blood, blood plasma or plasma expanders.
2. Provide Health Protection Services of the following types:
   a. Emergency sanitation measures for protection against contamination of food and water by radiological, chemical and biological means.
   b. Sewage and waste disposal.
   c. Insect and rodent control.
   d. Preventive and remedial measures for human needs in case of biological, chemical or radiological warfare.
3. Provide Mortuary Service facilities to include the following:
   a. Identification of the dead.
   b. Planning and supervision of permanent and emergency burial sites.
   c. Making and maintaining full records of actions taken in disposing of human remains.
   d. Close cooperation with Religious Affairs Services wherever possible.

An analysis of the services outlined in the foregoing will indicate the many services that will be within the normal Civil Defense function of every doctor in Alabama. It also emphasizes the need for professional personnel and substantial supplies. The responsibility of doctors must be observed fully by each for, and especially during an emergency, and under governmental authorization in Civil Defense, the doctor will operate within his

own technical knowledge and capacity for administering to the needs of the people.

Health conditions that are developed by living in compact fallout shelters will constitute a major overall problem for the Health Services within the Civil Defense operational readiness planning. Public fallout shelters, caring for 50 or more people—some accommodating several hundred people—are being provided throughout Alabama. Each of these shelters will require attention by the local Health Services, and among the shelterees will, as may be determined, be members of the medical profession. Special training and orientation relative to operations by doctors and other medical professional personnel within fallout shelters will be needed at every level.

Headquarters for the Civil Defense organization will be established in what is known as the Emergency Operations Center, a shielded building or space adequate to accommodate, if possible, all key Civil Defense service personnel, including the Health Services. In the absence of such a shielded building, operations would be necessary as may locally be arranged. Within the planning arrangement it will be essential that all doctors conform to some planning or understanding that will keep them available, and their whereabouts known to headquarters, at all times during the emergency.

Emergency from shelter would be something to anticipate following a period when radioactive fallout had endangered life outside shelters, and doctors must understand how to determine what areas may, or may not, be safe from radiation. Special training by doctors and other medical personnel is necessary in peace time, and before any nuclear attack occurs, in the area of treatment of patients who have been exposed to radiation in varying degrees.

The Doctor in Civil Defense represents one of the main keys to human survival from the effects of disaster—natural or nuclear—and this is well understood in the Civil Defense realm.

Mass Media To Carry Medical Self-Help Programs

The Civil Defense Washington Office has made a television film featuring Danny Thomas, along with television and radio spot announcements, press releases, cards for transit system buses, and promotional leaflets in order to give nationwide publicity to Medical Self-Help programs. Health and Civil Defense personnel in each county are asked to get in touch with local radio, television, and newspapers to make a request that these materials be used.

In order to help promote evaluation of the effectiveness of this publicity, it is requested that all physicians send a copy of articles and ads printed in local publications, along with a note telling of any radio, television or other local coverage that was given this program, to the following office:

Max G. Cain, Chief
Health Mobilization Section
Hospital Planning Division
State Office Building
Montgomery, Alabama 36104

Diabetes Association Schedules Conference

The American Diabetes Association will hold its Twelfth Postgraduate Course, **Diabetes in Review: Clinical Conference, 1965,** January 20, 21 and 22 at the Drake Hotel in Chicago, in co-operation with the Diabetes Association of Greater Chicago. The faculty will be composed of 32 outstanding authorities.

The Committee on Professional Education of the American Diabetes Association, chaired by T. S. Danowski, M. D., of Pittsburgh, Pa., president-elect of the association, is responsible for the Postgraduate Course Series.

The course is acceptable for accredited hours by the American Academy of General Practice. The three-day course is open to doctors of medicine. The fee is $40 for members of the American Diabetes Association; $75 for nonmembers.

Alabama Department of Public Health

New Environmental Laboratory

By WILLIAM T. WILLIS

Director, Division of Radiological Health
Bureau of Sanitation
Alabama Department of Public Health

The environmental laboratory of the Bureau of Sanitation of the Alabama Department of Public Health recently moved into new quarters in Montgomery. The move into new quarters and the consolidation of activities within the single laboratory has enabled the Bureau of Sanitation to increase its capabilities in the analysis of environmental samples. This laboratory is for the chemical, biochemical and physical analysis of samples and in no way duplicates the services rendered by the State Health Laboratory which is a separate bureau within the State Department of Health.

At the present time, there are three areas of interest in the laboratory of the Bureau of Sanitation. These are: the analysis of samples from public water supplies located throughout the state, the analysis of samples collected from various streams and waste discharges for unusual determinations which cannot conveniently be made in the field laboratories of the Water Improvement Commission and the analysis of environmental samples for an examination of the quantity and kind of radioactivity which might be present in these samples.



Aubrey Godwin, Chief Chemist, Radiological Health Laboratory

One of the functions of the Division of Public Water Supplies is to determine whether sources of water are wholesome, both from a bacteriological and a chemical standpoint. Bacteriological samples are



Edward Cowan, Acting Assistant Director, Division of Radiological Health

routinely collected and analyzed in the Alabama Department of Public Health, Bureau of Laboratories. On a less frequent basis, samples are collected from each public water supply throughout the state and a complete chemical analysis is made by the environmental laboratories to determine if the quality of the water is acceptable. When new facilities, such as a well, are put into operation, a complete analysis of the water is made. It is often possible to save the municipality a significant sum of money by determining whether or not such things as an iron removal plant is necessary for the new well. In this way, the laboratory performs a valuable function not only for the Division of Public Water Supply, but for the municipalities involved.

The Water Improvement Commission of the State of Alabama maintains a mobile field laboratory which is continuously testing the water quality in the streams throughout the state as well as the quantity of contaminants being discharged into the streams by municipal and industrial sources. At the present time, when the interest of the regulatory agencies is being directed more and more at the so called exotic contaminants, it is necessary that back-up facilities in the laboratories be available for the field laboratories. Some of the instrumentation required in the analysis of these exotic materials is not readily adaptable to use in mobile facilities such as trailer laboratories. For this reason, some of the more delicate instrumentation has been located in the Bureau of Sanitation's Environmental Health Laboratories. Here, whenever the need arises, some of the more complex chemical analyses can be made on industrial waste samples which are collected from industries throughout the state.

The most recent division to acquire laboratory facilities in the environmental health laboratory is the Division of Radiological Health. This Division is concerned with the detection of radioactive materials in the air we breathe, the water we drink, milk and other environmental media. It should be pointed out that the determination of these minute quantities of radioactivity in these media requires extensive instrumentation and elaborate chemical separation procedures. The laboratory is equipped with the necessary instruments and the personnel have the technical knowledge with which to perform the indicated determinations. An example of the work being done in the radiological section of the laboratory is the processing of air samples collected from sampling stations throughout the state on a daily basis to determine the levels of radioactivity in the air. Other analyses being made are: the determination of strontium,



John W. Pierce, Jr. (left) and Lloyd G. Linn, Jr. make tests.

cesium and iodine in milk and other food samples which are consumed daily by the public. Surface waters are also analyzed on a routine basis for samples that are collected from twenty-eight different sampling points on the streams throughout the state.

The development within the Bureau of Sanitation of laboratory capabilities for the analysis of various environmental samples collected throughout the state is in keeping with the trend toward considering the total environment when dealing with public health problems. The function of these laboratory facilities is to provide specialists in the Bureau of Sanitation with the necessary laboratory data upon which accurate assessments of potential public health problems involving the environment can be made.

BUREAU OF LABORATORIES

Thomas S. Hosty, Ph.D., Director

November 1964

Examinations for intestinal parasites	1,319
Typhoid cultures (blood, feces, urine and other)	207
Examinations for malaria	2
Examinations for gonococci	1,630
Serologic tests for syphilis (blood and spinal fluid)	21,303
Examinations for diphtheria bacilli and Vincent's	82
Complement fixation tests	52
Examinations for Negri bodies (smears and animal inoculations)	200
Water examinations	2,207
Milk and dairy products examinations	3,668
Examinations for tubercle bacilli	3,751
Miscellaneous examinations	4,564
Total	38,985

* * *

BUREAU OF PREVENTABLE DISEASES

W. H. Y. Smith, M. D., Director

CURRENT MORBIDITY STATISTICS

1964

	Oct.	Nov.	*E. E. Nov.
Tuberculosis	120	76	116
Syphilis	163	147	117
Gonorrhea	307	220	275
Chancroid	1	0	2
Typhoid fever	1	1	2
Undulant fever	0	0	0
Amebic dysentery	5	5	3
Scarlet fever & strep. throat	342	258	88
Diphtheria	10	5	9
Whooping cough	20	27	15
Meningitis	11	1	7
Tularemia	0	0	0
Tetanus	1	1	1
Poliomyelitis	0	0	6
Encephalitis	0	0	1
Smallpox	0	0	0
Measles	53	41	44
Chickenpox	10	14	25
Mumps	17	16	40
Infectious hepatitis	62	30	36
Typhus fever	0	0	0
Malaria	0	0	0
Cancer	964	523	462
Pellagra	0	0	0
Rheumatic heart	29	21	24
Rheumatic fever	26	14	15
Influenza	28	55	111
Pneumonia	162	142	170
Rabies—Human cases	0	0	0
Pos. animal heads	2	3	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

FDA Enforcing New Drug Advertising Law

From the Washington Office
American Medical Association

The Food and Drug Administration has started enforcing the prescription drug advertising provisions of the new law.

Sales of ethical drugs are now exceeding $2 billion a year in the United States. The Bureau of the Census reported ethical drug sales at $2.05 billion in 1963, the first year that they had gone over the $2 billion mark. The Pharmaceutical Manufacturers Association's figure was $2.39 billion.

The law requires that prescription drug advertisements show:

—The "established name" of the drug, if one exists, in type at least half as large as that used for the brand name;

—The drug's quantitative formula, and

—A true and non-misleading brief summary of information about adverse side effects, contraindications, and effectiveness of the drug for the guidance of physicians.

In enforcing these requirements, FDA said it would seek to determine whether a fair balance exists between the information on effectiveness and that on side effects and contraindications.

The FDA's Bureau of Medicine has started monitoring professional journal advertising for prescription drugs. It will forward violative advertisements with appropriate recommendations to the FDA Bureau of Regulatory Compliance.

Dr. Joseph F. Sadusk, Jr., Medical Director of FDA, said that it is the duty of physicians to keep fully informed of the composition, mode of action, efficacy and potential toxicity of drugs because as the potency of drugs increases, "so generally does their complexity and their potentiality for harm."

Violations of prescription drug advertising will be evaluated in two categories:

—Positive claims or omissions concerning the product which present potential danger to the patient in varying degrees. Examples include omission of some of the pertinent side effects, precautions or contraindications; improper statements about the effectiveness of, or indications for, the drug or antibiotic; omission of some of the information on various dosage forms, ingredients, or directions for use where required.

—Claims which may or may not involve danger to patient health but which, in the selling message, can seriously mislead as to the proper place of the drug or antibiotic in the total spectrum of products available to meet a specific disease situation.

* * *

The American Medical Association and the Food and Drug Administration have warned that two fever and pain-relieving drugs are causing fatal agranulocytosis, a blood disorder, in some patients.

The drugs are aminopyrine and dipyrone, closely related compounds which have been dispensed widely by prescription for many years. Drastic label changes restricting the recommended uses for the drugs were announced by FDA. An editorial supporting the FDA action was carried in the AMA's journal, JAMA.

The FDA ruling was based on case reports collected by AMA and on recommendations

of a special committee of medical experts in the fields of hematology, internal medicine, neurology, pediatrics and pharmacology.

* * *

Nearly one million more people were admitted to hospitals in the U. S. in 1963 than in the previous year, according to the Health Insurance Institute.

The Institute said that American Hospital Association statistics showed a record 25,267,000 Americans, or one of every seven, were hospitalized last year. This represented an increase of 960,000 over 1962. This meant that each day more than 69,000 persons entered non-federal short-term general and other special hospitals, and that on an average day in 1963 there were 530,000 patients—2.8 persons per 1,000 population—under hospital confinement.

There were 698,000 beds available for patients in 1963, an average of 3.7 beds per 1,000 population.

The AHA, which includes terminal hospitalizations in its survey, found the average hospital stay for all ages to be 7.7 days. A study conducted by the U. S. National Health Survey, which included federal hospitals, and was based on representative household interviews, put the average hospital stay at 9.4 days. It did not include terminal hospital stays.

The NHS report showed that persons with health insurance protection averaged shorter hospital stays than those with no insurance protection at all. This may indicate, the report suggested, that persons with health insurance protection will seek hospital care more often for diagnosis or for less serious illness than the uninsured.

The number of persons protected by hospital expense insurance provided by insurance companies, Blue Cross, Blue Shield and other health care plans, rose to 145,329,000 by the end of 1963, the Institute said.

Benefits paid by these organizations toward the costs of hospital care totaled $4,544,000,000, or an average of $12.5 million a day. Total health insurance benefits amounted to $7.8 billion.

A Presidential Study Commission has recommended a $2.9 billion program on heart disease, cancer and stroke.

The research and treatment plan would be built around a network of regional centers designed to learn more about these diseases which cause 70 per cent of American deaths.

The study group was set up by President Johnson in March and commissioned to draw up a blueprint for improving national facilities for fighting these diseases. At present the government is spending about $220 million in the research and treatment areas covered by the report.

The group urged establishment of a network of regional heart disease, cancer and stroke centers "for clinical investigation, teaching and patient care."

These would be located in universities, hospitals, research institutes and other institutions.

Included would be 25 centers for heart disease, 20 for cancer and 15 for stroke to be established over a five-year period.

The program also would include a second national network of "diagnostic and treatment stations" located in communities throughout the nation. The purpose of this would be "to bring the highest medical skills in heart disease, cancer and stroke within reach of every citizen." This plan envisions over a five-year period 150 stations for heart disease, 200 for cancer and 100 for stroke.

The group also urged "a broad and flexible program of grant support" to stimulate more advanced research efforts in university medical schools, hospitals and other health care centers.

It suggested that the Public Health Service receive $25 million for such grants the first year which would be raised to $75 million the fifth year of operation.

The American Medical Association withheld comment on the report for the time being.

"If, however, legislation is introduced in the Congress calling for implementation of the program, the A. M. A. will react at that time," a spokesman said.

The Woman's Auxiliary



Dear Doctors:

I've just returned from the Southern Medical Association Convention in Memphis, Tennessee, where I saw Mrs. William G. Thuss, Sr., of Birmingham, installed as President-Elect of the Woman's Auxiliary to the Southern Medical Association. This column is dedicated to, and a report to you on, the activities of two members of the Woman's Auxiliary to the Medical Association of the State of Alabama on behalf of organized medicine on the county, state, southern, and national levels. They have represented you with intelligence and charm and I thought you might like to hear what they have done. They are Mrs. William G. Thuss, Sr., of Birmingham and Mrs. John M. Chenault of Decatur.

Belle Chenault was Alabama's state auxiliary president in 1954-55 and Louise Thuss was state president in 1955-56. Since that time they have served on the board of directors, as national officers, or as national committee chairmen for the Woman's Auxiliary to the American Medical Association.

Louise Thuss has received the highest honor that an auxiliary member can attain, president of the national auxiliary, in 1962-63. She has been a director, district vice-president, first vice-president, president-elect, member of the nominating committee, as well as president of the national auxiliary. She was president of the Woman's Auxiliary to the International College of Surgeons last year and has, as I told you above, just been installed as president-elect of the Woman's Auxiliary to the Southern Medical Association during the convention in Memphis.

Belle Chenault has been Today's Health Chairman, Rural Health Chairman, a Director, Nominating Committee member, and first vice-president on the national level. Belle is a past-president of the Woman's Auxiliary to the Southern Medical Association.

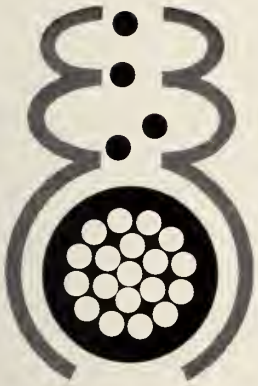
There are thirty-six elective or appointive offices in the national auxiliary. No greater testimony to Louise's and Belle's intelligence, hard work, and ability to get along with people could be given than that two of the offices have been filled by them for the past eight years when both are from the same state.

I am not only proud of Louise and Belle for representing us so well on the national level but I am also proud that their interest and work on behalf of their county auxiliaries and the state auxiliary has never diminished. They have another wonderful trait. They remember to look after the state delegates, the president-elect and the president at the national convention and at the fall conference in Chicago. They are important people but they are not imbued with their importance. Too few of us have this quality.

As president of your auxiliary, I think you need to know how well these two fine women have represented our state on a national level. Some of you know them through their active husbands. Their graciousness, charm, and ability have made them known in their own right all over the United States.

Sincerely,

Frances Clemmons



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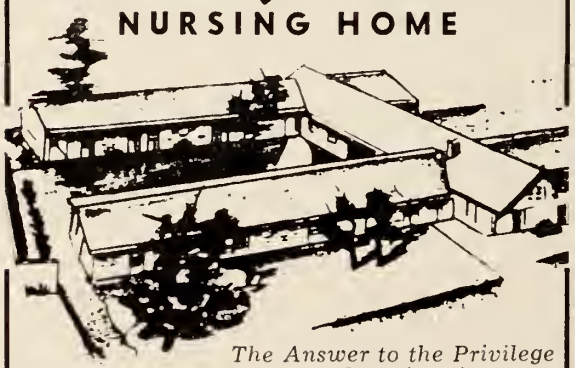
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carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

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BRIEF SUMMARY

'SOMA' COMPOUND; 'SOMA' COMPOUND plus CODEINE: carisoprodol, acetophenetidin, caffeine, codeine phosphate. *Warning: Codeine may be habit-forming.* **Indications:** 'Soma' Compound and 'Soma' Compound with Codeine are indicated for relief of pain and stiffness in traumatic, rheumatic and other similar conditions. **Contraindications:** Allergic or idiosyncratic reactions to carisoprodol or codeine. **Precautions:** *Acetophenetidin*—May damage the kidneys when used in large amounts or for long periods. *Codeine*—Should be used with caution in addiction-prone individuals. *Carisoprodol*—Like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate. **Side effects:** *Codeine*—Nausea, vomiting, constipation, and miosis. *Carisoprodol*—The only side effect reported with any frequency is drowsiness, usually on higher than recommended doses. One instance each of pancytopenia and leukopenia occurring when carisoprodol was administered with other drugs has been reported as has an instance of fixed drug eruption with carisoprodol and subsequent cross-reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. Other rarely observed reactions have included dizziness, ataxia, agitation, increase in eosinophil count, and gastrointestinal symptoms. Massive overdosage may produce coma and/or mild shock and respiratory depression. **Dosage:** 'Soma' Compound and 'Soma' Compound with Codeine, one or two tablets three times daily and at bedtime. **Supplied:** 'Soma' Compound, orange tablets, each containing carisoprodol 200 mg., acetophenetidin 160 mg., and caffeine 32 mg. 'Soma' Compound with Codeine, white, lozenge-shaped tablets, each containing carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., and codeine phosphate 16 mg. Narcotic order form required. *Before prescribing, consult package circular.*

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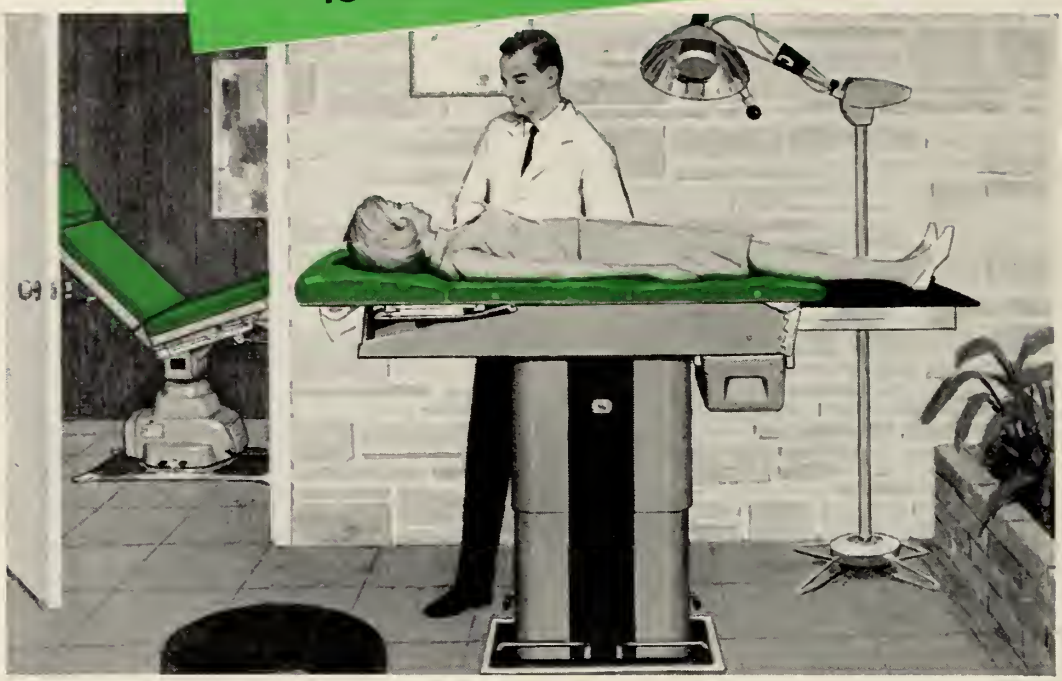
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6. Please list the professional journals you read in order of preference. (You may show your opinion of your state medical journal by its position on this list.)

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   2. _____ 5. _____
   3. _____ 6. _____

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(1) *Bibby, Basil G. D.M.D., PH.D., et al "Evaluation of Caries-Producing Potentialities of Various Foodstuffs" Jl of Am Dent Assn; vol 42, May '51, pps 491-509*

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Dermatology
Maurice L. Kelley, Jr., M. D., Rochester, N. Y.
Gastroenterology
Robert I. Wise, M. D., Philadelphia, Pa.
General Practice
Curtis J. Lund, M. D., Rochester, N. Y.
Gynecology
S. Gilbert Blount, Jr., M. D., Denver, Colo.
Internal Medicine
Jerome W. Conn, M. D., Ann Arbor, Mich.
Internal Medicine
Francis Murphey, M. D., Memphis, Tenn.
Neurologic Surgery
Bayard Carter, M. D., Durham, N. C.
Obstetrics
William F. Hughes, M. D., Chicago, Ill.
Ophthalmology
Milton S. Thompson, M. D., San Antonio, Tex.
Orthopedic Surgery
Benjamin Castleman, M. D., Boston, Mass.
Pathology
Harry C. Shirkey, M. D., Birmingham, Ala.
Pediatrics
Richard H. Marshak, M. D., New York, N. Y.
Radiology
Warren H. Cole, M. D., Chicago, Ill.
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NEW ORLEANS, LOUISIANA —:— MARCH 4-6, 1965

Sponsored by the DIVISION OF NEUROLOGY AND PSYCHIATRY OF TOURO INFIRMARY under a National Institute of Mental Health Grant.

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WILLIAM SHEELEY, M. D., Director of Psychiatry and Medical Practice Project of the A. P. A., Washington, D. C.
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"Medical Practitioners and Supportive Handling of Schizophrenia"
"Adolescence—Disturbed and Disturbing"
"The Physician and His Reaction to the 'Crock'"
"Newer Thoughts About the Therapy of Alcoholism"
"Medical Conditions with Psychiatric Manifestations"
"Recognition and Treatment of Depressive Reactions by Medical Practitioners"
"Treatment of Emotional States by the Medical Practitioner"

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Touro Infirmary
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BUREAU OF VITAL STATISTICS

Ralph W. Roberts, M. S., Director

PROVISIONAL BIRTH AND DEATH STATISTICS AND COMPARATIVE DATA, OCTOBER, 1964

Live Births / Deaths / Causes of Death	Number Registered During October 1964			Rates* (Annual Basis)		
	Total	White	Non-White	1964	1963	1962
Live Births	6,852	4,501	2,351	23.8	23.9	23.8
Deaths	2,654	1,738	916	9.2	8.7	8.8
Fetal Deaths	144	55	89	20.6	12.2	19.2
Infant Deaths—						
under one month	158	85	73	23.1	22.4	21.9
under one year	218	109	109	31.8	30.3	28.7
Maternal Deaths	1		1	1.4	10.0	4.4
Causes of Death						
Tuberculosis, 001-019	21	10	11	7.3	10.5	7.8
Syphilis, 020-029	4	3	1	1.4	1.4	1.1
Dysentery, 045-048	2		2	0.7		0.4
Diphtheria, 055	1		1	0.3		
Whooping cough, 056						
Meningococcal infections, 057	3	1	2	1.0	1.4	0.4
Poliomyelitis, 080, 081						
Measles, 085	1		1	0.3		
Malignant neoplasms, 140-205	374	271	103	129.7	123.6	130.5
Diabetes mellitus, 260	48	30	18	16.6	10.8	10.2
Pellagra, 281						0.4
Vascular lesions of central nervous system, 330-334	382	244	138	132.4	111.4	120.6
Rheumatic fever, 400-402					0.3	1.1
Diseases of the heart, 410-443	850	618	232	294.7	285.6	291.6
Hypertension with heart disease, 440-443	97	40	57	33.6	40.2	43.4
Diseases of the arteries, 450-456	58	37	21	20.1	20.2	16.9
Influenza, 480-483	2	1	1	0.7	1.0	1.4
Pneumonia, all forms, 490-493	68	34	34	23.6	22.3	19.0
Bronchitis, 500-502	5	5		1.7	1.4	1.1
Appendicitis, 550-553	1		1	0.3	0.7	0.7
Intestinal obstruction and hernia, 560, 561, 570	17	12	5	5.9	4.5	6.7
Gastro-enteritis and colitis, under 2, 571.0, 764	10	5	5	3.5	4.5	3.9
Cirrhosis of liver, 581	18	12	6	6.2	9.1	7.0
Diseases of pregnancy and childbirth, 640-689	1		1	1.4	10.0	4.4
Congenital malformations, 750-759	26	20	6	3.8	4.7	6.2
Immaturity at birth, 774-776	43	20	23	6.3	7.3	8.1
Accidents, total, 800-962	180	123	57	62.4	60.1	61.7
Motor vehicle accidents, 810-835, 960	91	59	32	31.6	29.7	36.3
All other defined causes	393	239	154	136.3	127.5	123.1
Ill-defined and unknown causes, 780-793, 795	146	53	93	50.6	45.0	43.7

*Rates: Birth and death—per 1,000 population
Infant deaths—per 1,000 live births
Fetal deaths—per 1,000 deliveries
Maternal deaths—per 10,000 deliveries
Deaths from specified causes—per 100,000 population



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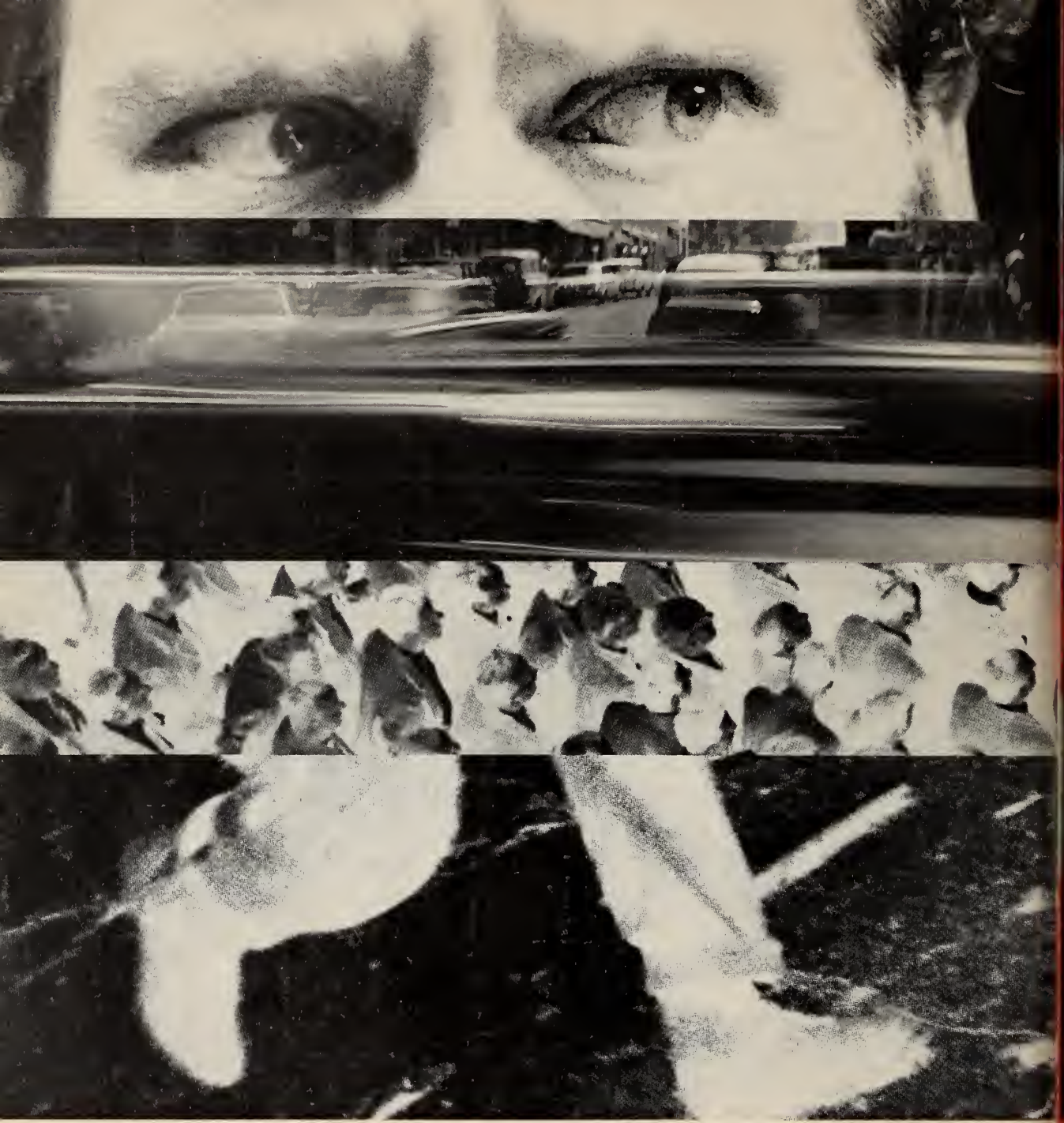
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*Spaulding, W. B.; Spitzer, W. O., and Truscott, P. W.: Canad. M. A. J. *89*:329, 1963.

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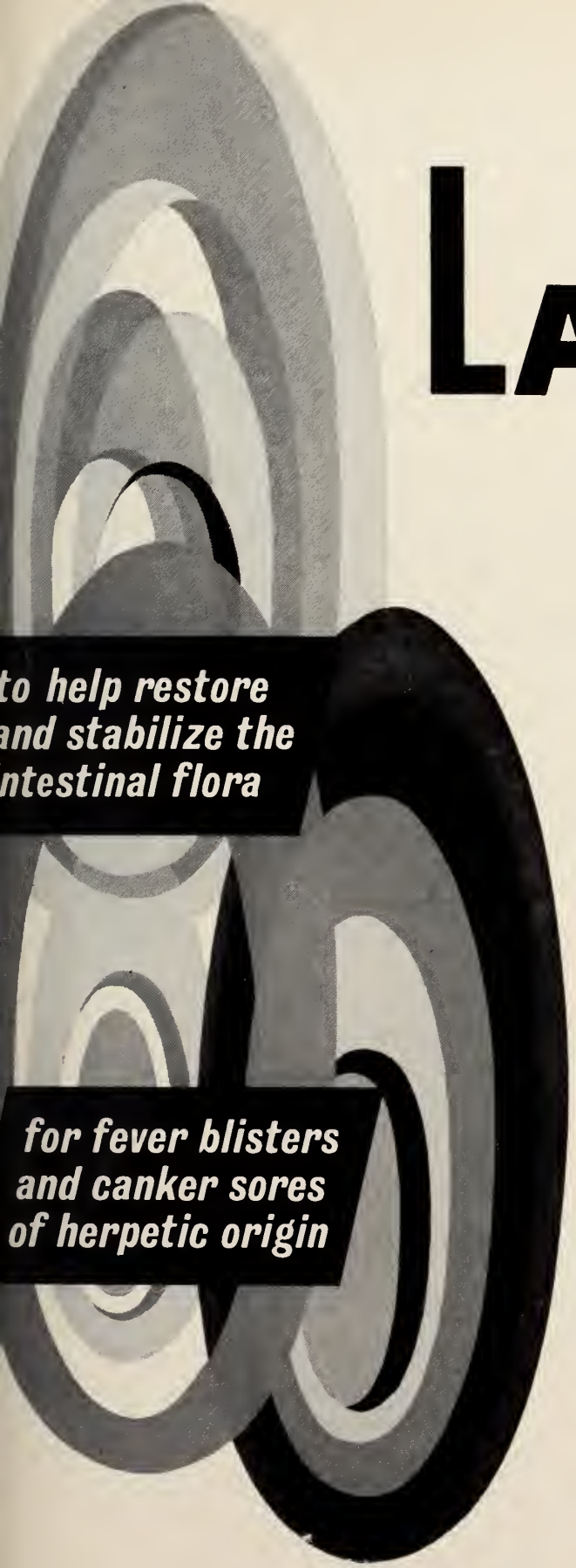
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(1) Frykman, H.M.: Minn. Med., Vol. 38, Jan. 1955. (2) Poth, E.J.: The J.A.M.A., Vol. 163, No. 15, April 13, 1957. (3) McGivney, J.: Texas State Jour. of Med., Vol. 51, No. 1, Jan. 1955. (4) Stern, F. H.: Jour. of The Amer. Ger. Soc., Vol. 11, No. 3, Mar. 1963. (5) Weekes, D. J.: N.Y. State Jour. of Med., Vol. 58, No. 16, Aug. 1958. (6) Abbott, P.L.: Jour. of Oral Surg., Anes. & Hosp. Dental Serv., Vol. 19, July 1961. (7) Weekes, D. J.: E.E.N.T. Digest, Vol. 25, No. 12, Dec. 1963.

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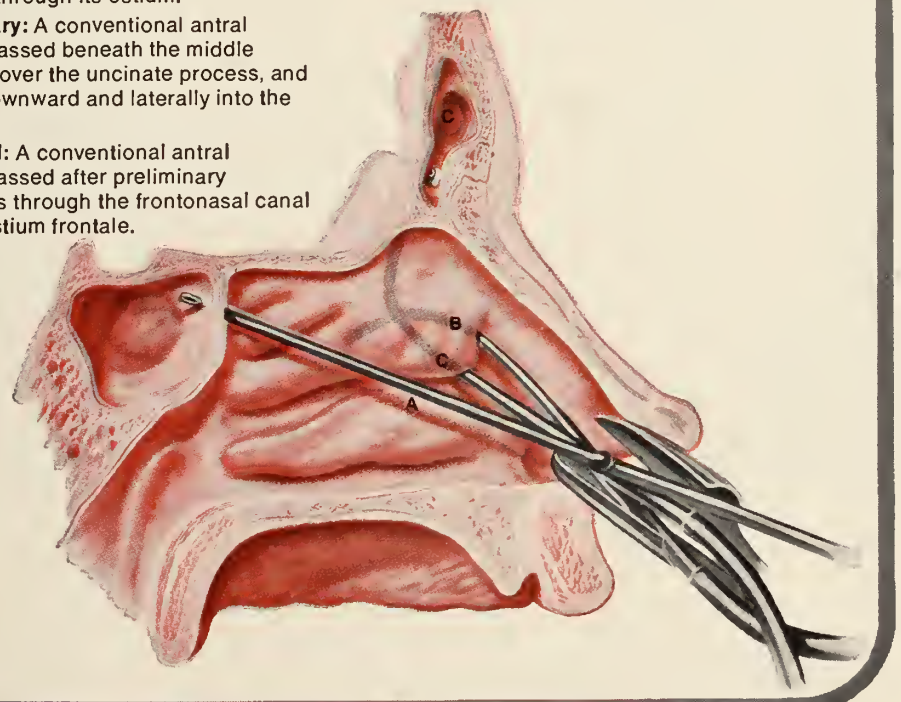
Woman's Auxiliary 248

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Sagittal anatomical section of nasal cavity showing approach for probing or irrigation by cannulas.

A—Sphenoid: A sphenoid cannula (under 13.5 cm.) passed around the middle and superior turbinates to the anterior wall of the sinus through its ostium.

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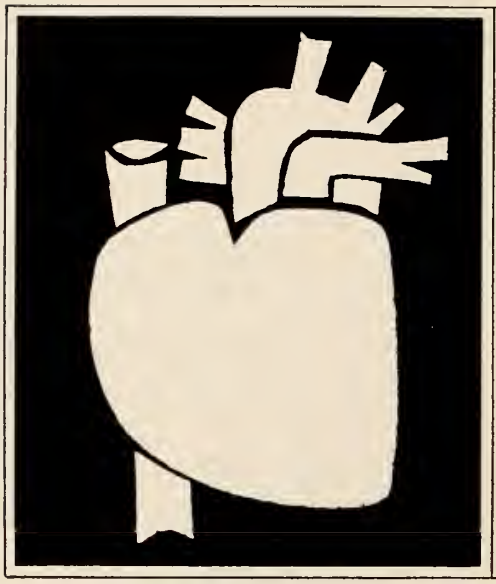
*Reed, G. F.: Sinusitis, New England J. Med. 267:402, Aug. 23, 1962.

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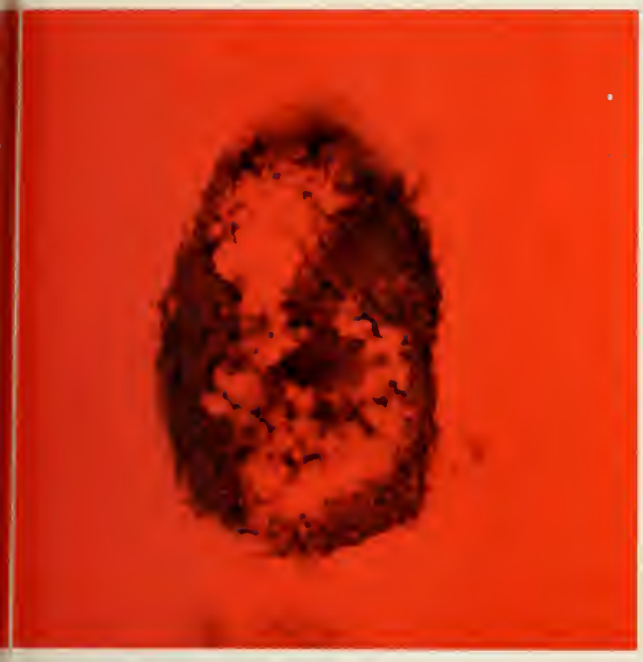
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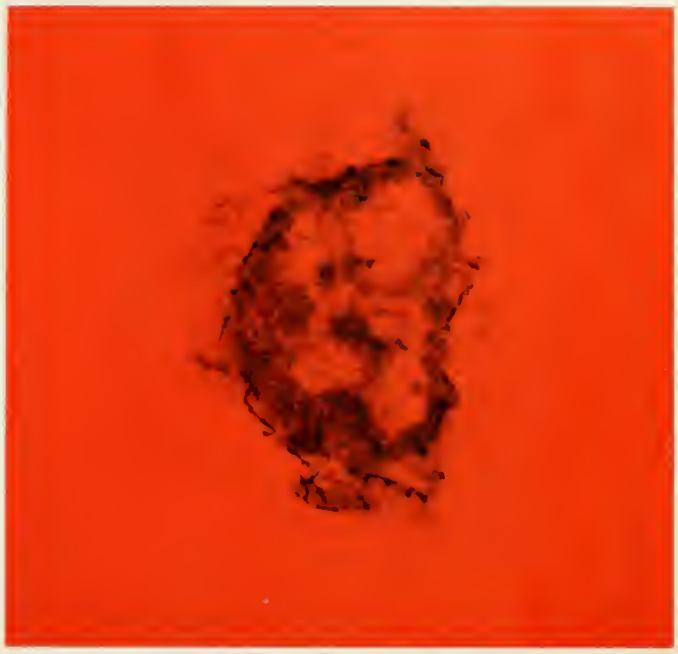
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References: 1. Millard, F. J. C., and Batten, J. C.: Brit. M. J. *i*:1159 (April 28) 1962. 2. Ivler, D., *et al.:* Abstracts, Third Interscience Conference on Antimicrobial Agents and Chemotherapy, October 1963, p. 32. 3. Stewart, G. T.: Pharmakotherapia *1*:197, 1963. (Progress in Drug Therapy). 4. Grant, I. W. B., *et al.:* Brit. M. J. *ii*:482 (Aug. 18) 1962. 5. Millard, F. J. C., and Batten, J. C.: Brit. M. J. *i*:644 (March 9) 1963. 6. Oswald, N. C.: Postgrad. Med. *35*:233 (March) 1964. 7. Howells, C. H. L., and Tyler, L. E.: Brit. J. Clin. Pract. *17*:321 (June) 1963. 8. May, J. R., and Delves, D. M.: Thorax *19*:298, 1964. 9. May, J. R., *et al.:* Lancet *ii*:444 (Aug. 29) 1964. 10. Pines, A.: Lancet *ii*:445 (Aug. 29) 1964.

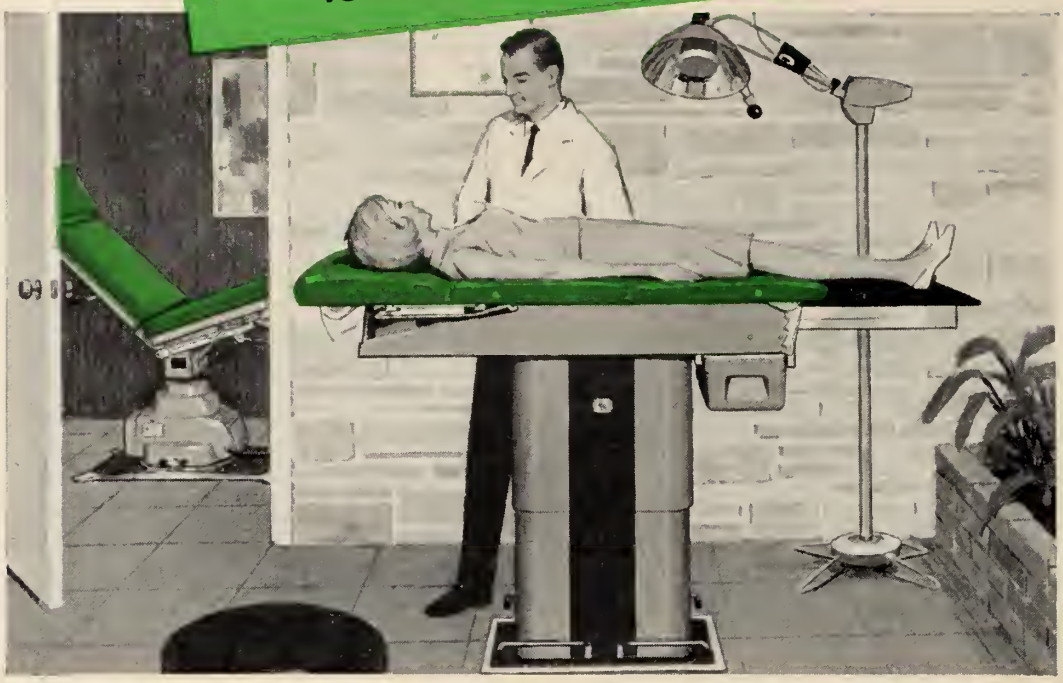
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Each capsule contains:

Butazolidin®, brand of phenylbutazone	100 mg.
dried aluminum hydroxide gel	100 mg.
magnesium trisilicate	150 mg.
homatropine methylbromide	1.25 mg.

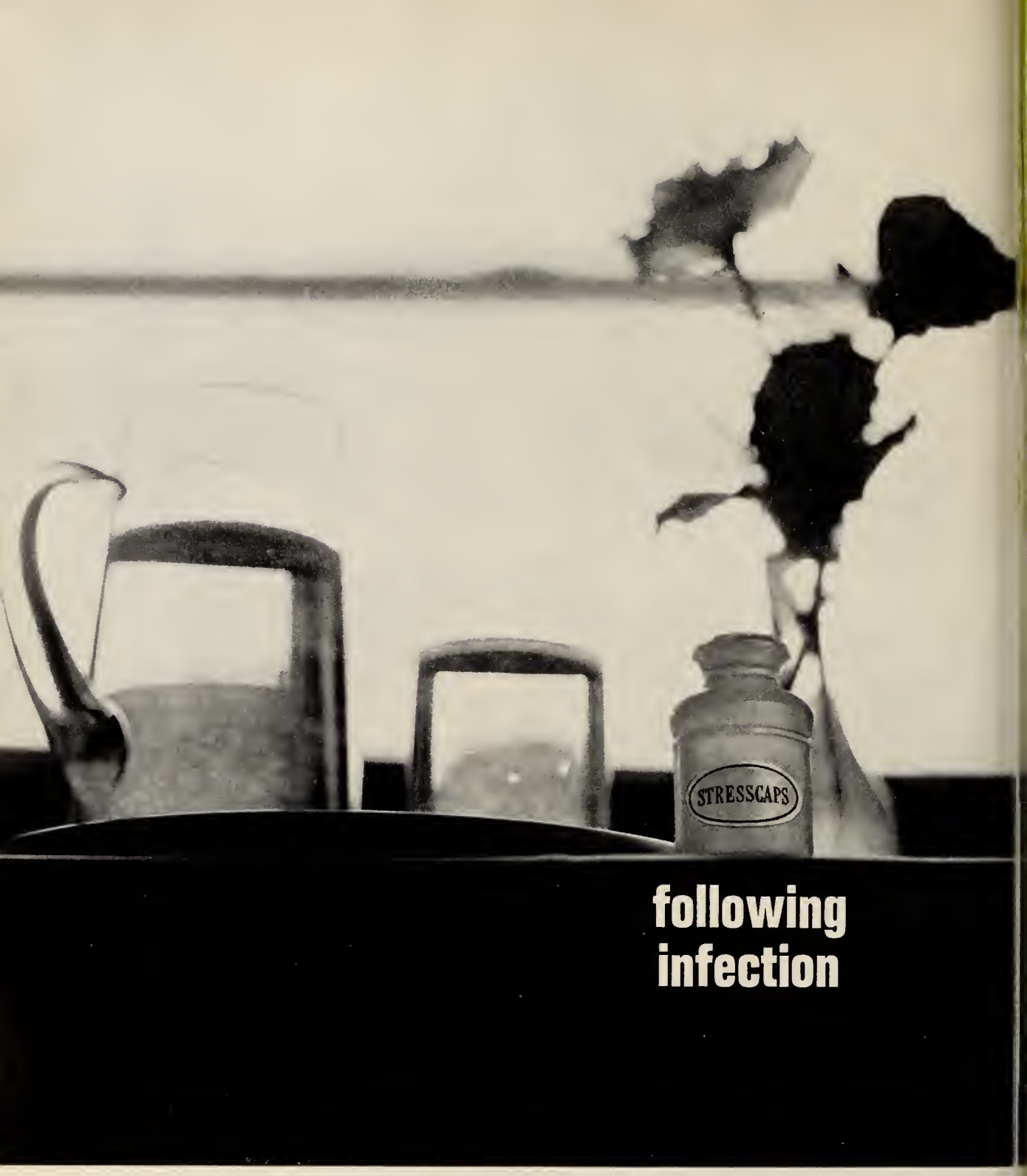
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brand of phenylbutazone

Tablets of 100 mg.

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following infection

STRESSCAPS B and C vitamins in therapeutic amounts...help the body mobilize defenses during convalescence...aid response to primary therapy. The patient with a severe infection, and many others undergoing physiologic stress, may benefit from STRESSCAPS.

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Vitamin B_1 (as Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 (one month's supply) and 100 (three months' supply).

STRESSCAPS®

Stress Formula Vitamins Lederle

FOR PROFESSIONAL RECOMMENDATION ONLY

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY Pearl River, N.Y. Lederle

8b93-4



IF YOU COULD BUT SEE PAIN

If you could see pain itself—not merely the reaction to pain—how much more accurately you could appraise it! How much better you could note the effectiveness with which codeine—in safe, low dosage—can confer full codeine benefits, when its action is potentiated by simple analgesics, and enhanced by phenobarbital! This is what PHENAPHEN WITH CODEINE provides, to enable you to "get the best out of codeine"



with maximal safety from the risk of incurring codeine side effects. ●●●●●●●●●●●●●●●●

Contraindications: Hypersensitivity to any ingredient. Precautions: As with all phenacetin-containing products, avoid excessive or prolonged use. Side effects: Side effects are uncommon—nausea, constipation and drowsiness have been reported. ●●●●●●●●●●●●●●●●

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PHENAPHEN® WITH CODEINE

Provides the basic Phenaphen formula, plus Codeine phosphate (Warning: may be habit forming) in three strengths: ¼ gr. (Phenaphen No. 2); ½ gr. (Phenaphen No. 3); and 1 gr. (Phenaphen No. 4). Basic Phenaphen formula: Phenacetin (3 gr.) 194.0 mg.; Aspirin (2½ gr.) 162.0 mg.; Phenobarbital (¼ gr.) 16.2 mg. (Warning: may be habit forming); and Hyoscyamine sulfate 0.031 mg.


There's nothing like a vacation*
for relaxing stress-induced smooth muscle spasm

nothing, that is, except the

sedative-antispasmodic action of DONNATAL®

Functional disturbances of gastrointestinal tone and motility present the physician with an all too common reaction to the stressful dilemmas and frustrations of modern living.[3,6]

For their dependable control, no better spasmolytic has ever been discovered than the *natural* belladonna alkaloids in combination with phenobarbital, as in DONNATAL.

Phenobarbital, as a mild sedative, has the benefit of long use and a reassuring record of freedom from unexpected and untoward reactions. In allaying subjective tension, it helps to prevent emotional stimuli from provoking or intensifying visceral spasm.

The *natural* belladonna alkaloids in DONNATAL—conforming to the classic formulation by Vollmer[5]—selectively include only the therapeutically desired alkaloids in precisely and optimally balanced ratio. The clinical uncertainties of the variable tincture and extract of belladonna are thus avoided.

Further, a recent pharmacological study has confirmed that the antispasmodic effectiveness of the belladonna alkaloids in DONNATAL is measurably potentiated by the presence of phenobarbital.[8]

Over the years, the professional consensus has reflected broad clinical confidence in the marked benefits to be achieved by DONNATAL in a wide range of visceral disorders... in peptic ulcer,[1,6] functional bowel distress,[1] gastrointestinal spasm and discomfort,[2] and other functional disturbances of visceral smooth muscle.

CONTRAINDICATIONS: Glaucoma, advanced renal or hepatic disease or hypersensitivity to any of the ingredients.

PRECAUTIONS: Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction as in prostatic hypertrophy.

SIDE EFFECTS: Blurring of vision, dry mouth, difficult urination or flushing and dryness of the skin may occur at higher dosage levels, rarely at the usual dose.

*This one at Oak Creek, Castle Rock, Arizona

References: 1. Hock, C. W.: Clin. Med. 8:1932, 1961. 2. Marks, L.: Am. J. Gastroenterol. 27:180, 1957. 3. Palmer, W. L., and Kirsner, J. B.: Therapeutics in Internal Medicine, 2nd ed., F. A. Kyser, Ed., Hoeber, New York, 1953, p. 368. 4. Ryan, J. P., Jenkins, H. J. and Robinson, S. M.: J. Pharmaceut. Sciences 53(9):1084, 1964. 5. Vollmer, H.: Arch. Neurol. & Psychiat. 43:1057, 1940. Abst. J.A.M.A. 115:333, 1940. 6. Wharton, G. K., Balfour, D. C., Jr., and Osman, K. I.: Postgrad Med. 21:406, 1957.

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Prescribed by more physicians than any other antispasmodic —well over 5 billion doses!

Donnatal®

Robins

In each Tablet, Capsule or 5 cc. Elixir		*In each Extentab®*	*In each Tablet, Capsule or 5 cc. Elixir*		*In each Extentab®*
0.1037 mg.	hyoscyamine sulfate	0.3111 mg.	0.0065 mg.	hyoscine hydrobromide	0.0195 mg.
0.0194 mg.	atropine sulfate	0.0582 mg.	16.2 mg. (¼ gr.)	phenobarbital (¾ gr.)	48.6 mg.

(Warning: May be habit forming.)



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...is just for the sneeze

but for symptomatic relief of the common cold...

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TABLETS

Each layered tablet contains:

'Sudafed'® brand Pseudoephedrine Hydrochloride	20 mg.
'Perazil'® brand Chlorcyclizine Hydrochloride	15 mg.
Phenacetin	150 mg.
Aspirin	200 mg.
Caffeine	30 mg.

To relieve the aches, pains, fever and respiratory congestion of the common cold, flu or grippe with one product ...specify 'Emprazil'.

Caution: While pseudoephedrine is virtually without pressor effect in normotensive patients, it should be used with caution in hypertension. Also, while chlorcyclizine has a low incidence of antihistaminic drowsiness, the usual precautions should be observed.

Supplied: Bottles of 100 and 1000.

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Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.



Of 425 patients with confirmed G.I. infections... 387 or 91.1% were treated successfully with Signemycin®

Note:
Loughlin and co-workers* achieved cure (absence of parasites) in all 100 of their patients with *chronic amebic colitis*. Feces became negative in all within the planned ten-day period of Signemycin administration. Upon re-examination of the feces six weeks later, the offending pathogen *(E. histolytica)* had reappeared in only 7 cases.

*Loughlin, E. H. et al.: Antibiot. Med. 7:739, Dec., 1960.

Condition	No. of Patients	No. Responded to Signemycin
Amebiasis	237	222
Cholecystitis and cholangitis	105	97
Enteritis	41	31
Peritonitis	15	14
Various, including pancreatitis, appendicitis and colitis	27	23
Totals	425	387 (91.1%)

consistently effective...often when others fail

Signemycin®

tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Also available as Syrup, Pediatric Drops, and half-strength Capsules

Brief Summary and Bibliography follow.

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ACHROCIDIN®

Tetracycline HCl-Antihistamine-Analgesic Compound

Each tablet contains:			
ACHROMYCIN® Tetracycline HCl	125 mg.	Caffeine	30 mg.
Acetophenetidin (Phenacetin)	120 mg.	Salicylamide	150 mg.
		Chlorothen Citrate	25 mg.

Effective in controlling tetracycline-sensitive bacterial infection and providing symptomatic relief in allergic diseases of the upper respiratory tract. Possible side effects are drowsiness (so one should not drive while on drug), slight gastric distress, overgrowth of nonsusceptible organisms. Tooth discoloration may occur if given during tooth formation (late pregnancy, the neonatal period, early childhood). Reduce dosage in impaired renal function. Increased intracranial pressure is a possible complication in infants. Average adult dosage: 2 tablets four times daily, given at least 1 hour before or 2 hours after meals.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N.Y. Lederle

6866-5



Of 748 patients with confirmed G.U. infections... 684 or 91.4% were treated successfully with Signemycin®

Note:
The efficacy of Signemycin was shown in a study of nongonococcal urethritis involving over 1600 patients.* A comparison of the cure rates of sixteen antibiotic and chemotherapeutic agents revealed that Signemycin had the highest incidence of successful response. One hundred and six patients were treated, of which 82 were followed, with cures in 70.

*Willcox, R. R. and Rosedale, N.: Brit. J. Vener. Dis. 38:19, Mar., 1962.

Condition	No. of Patients	No. Responded to Signemycin
Cystitis	29	25
Pyonephritis	30	28
Pyelocystitis	119	112
Prostatitis	14	13
Gonorrhea	66	64
Lymphogranuloma venereum	96	96
Syphilis	31	31
Urethritis, nonspecific	149	131
Various, including infections seen with impaired urinary flow or lithiasis	214	184
Totals	748	684 (91.4%)

consistently effective...often when others fail

Signemycin®

tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Also available as Syrup, Pediatric Drops, and half-strength Capsules

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SIGNEMYCIN®

Side Effects: Glossitis and allergic reactions, as well as severe anaphylactoid reactions, have been reported as rare side effects. Should significant reaction or idiosyncrasy occur, discontinue medication and institute countermeasures. Use of tetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. Reduce usual oral dosage and consider serum level determinations in patients with impaired renal function to prevent possible liver toxicity due to excessive accumulation of antibiotic in the serum.

Precautions: Overgrowth of nonsusceptible organisms may occur. In such cases, discontinue medication and institute appropriate specific therapy as indicated by susceptibility testing. Aluminum hydroxide gel given with antibiotics has been shown to decrease their absorption and is contraindicated. The coloring agents used in Signemycin Syrup and Pediatric Drops may produce red discoloration of stools.

Triacetyloleandomycin, a constituent of Signemycin, administered to adults in daily oral doses of 1.0 Gm. (3 Gm. Signemycin) for periods of more than ten days may produce hepatic dysfunction and jaundice. In the rare patient who requires this high dosage level of Signemycin initially, liver function should be carefully followed and dosage should be reduced, as promptly as possible, to the usual recommended range of 1.0 to 2.0 Gm. per day. Therefore, Signemycin is recommended primarily for the treatment of acute or severe infections, with treatment restricted to a ten-day period. If clinical judgment dictates continuation of therapy beyond ten days, serial monitoring of the liver profile should be carried out, including BSP, transaminase, and cephalin flocculation tests. Changes observed in liver function were reversible following discontinuation of the drug.

Formulas: Capsules: 250 mg. Signemycin (167 mg. tetracycline HCl and 83 mg. oleandomycin as triacetyloleandomycin).

Capsules: 125 mg. Signemycin (83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin).

Syrup: 125 mg. Signemycin (tetracycline equivalent to 83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin) per 5 cc.

Pediatric Drops: 100 mg. Signemycin (tetracycline equivalent to 67 mg. tetracycline HCl and 33 mg. oleandomycin as triacetyloleandomycin) per cc.

More detailed professional information available on request.

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Of 5,057 patients with confirmed infections of all body systems... 4,731 or 93.5% were treated successfully with Signemycin®

Note:

The high rate of response to Signemycin in these cases is noteworthy because the totals include many patients with difficult-to-treat infections, many whose infections had proved resistant to other agents, and many who had been treatment failures on other therapy.[1-87] In addition the following criteria were used for the cases cited: (1) only published results were used (2) results were confirmed by clinical and/or laboratory findings (3) patients were cured, not "improved" (4) dosage conformed with current recommendations in the United States (5) no other anti-infective agents were used concomitantly (6) no instance of prophylactic use was included in these tabulations.

Condition	No. of Patients	No. Responded To Signemycin
Ear, nose and throat infections	507	465
Respiratory infections	1,028	954
Gastrointestinal infections	425	387
Genitourinary infections	748	684
Skin and soft-tissue infections	1,088	1,036
Bone and joint infections	71	64
Deep-seated or generalized infections	257	251
Obstetrical & gynecological infections	341	320
Miscellaneous conditions	592	570
Totals	5,057	4,731 (93.5%)

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Signemycin®

tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Also available as Syrup, Pediatric Drops, and half-strength Capsules

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not all but *Most* bacterial respiratory tract infections yield to ⟶



therapeutically the *Most* active erythromycin

In the patient, Ilosone *eradicates*, rather than merely inhibits, streptococci and pneumococci. This increased action is due to the fact that more erythromycin reaches the infection site because Ilosone (1) is acid stable in the stomach, even in the presence of food, and (2) is better absorbed from the intestine.

Ilosone produces peak levels of antibacterial activity *two* to *four* times those of other erythromycin preparations. Furthermore, these peak levels are attained earlier with Ilosone and are maintained much longer.

Side-Effects: Even though Ilosone is the most active oral form of erythromycin, the incidence of side-effects is low. Infrequent cases of drug idiosyncrasy, manifested by a form of intrahepatic cholestatic jaundice, have been reported. There have been no known fatal or definite residual effects. Gastro-intestinal disturbances not associated with hepatic effects are observed in a small proportion of patients as a result of a local stimulating action of Ilosone on the alimentary tract. Although allergic manifestations are uncommon with the use of erythromycin, there have been occasional reports of urticaria, skin eruptions, and, on rare occasions, anaphylaxis. **Contraindications:** Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction. **Dosage:** *Children under 25 pounds*—5 mg. per pound of body weight every six hours. *Children 25 to 50 pounds*—125 mg. every six hours. *Adults and children over 50 pounds*—250 mg. every six hours. For severe infections, these dosages may be doubled. Ilosone Chewable tablets should be chewed or crushed and swallowed with water.

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THE JOURNAL
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Certain Axioms and Fundamental Procedures Which Have Been Found Important In Fifty Years Of Treating Recent Fractures

H. EARLE CONWELL, M. D., F. A. C. S.
Birmingham, Alabama

1. There will always be those who will forget to use certain methods that they have found in the past to be most beneficial.
2. Too frequently there are ambitious surgeons who do not use their own experience and good judgment which, when properly employed, would lead to many more successful surgical procedures. The surgeon must have sharp eyes at the ends of his fingers and not always a scalpel.
3. Adjust your personality to the patient's personality and try to persuade his personality to yours at all stages of convalescence and then there will be better co-operation between patient and doctor, making it easier to carry out proper care.



Dr. Conwell is Associate Professor Emeritus, Orthopaedic Surgery, University of Alabama Medical College, a Life Counsellor, Medical Association of the State of Alabama, and Chief, Conwell Orthopaedic Clinic.

At the Annual Meeting of the Medical Association of the State of Alabama in April, Dr. Conwell will become a member of the Fifty Year Club and will be awarded the Certificate of Distinction for having practiced medicine for fifty years.

4. There is no mechanical equipment or laboratory test which can compute a patient's pain or the necessary compassion which the doctor should have.
5. Consideration of the patient's general condition comes first. Then associated complications and other factors can be considered, such as: severity of the local

trauma and then severity of bone damage. Use gentle handling before surgery thereby preventing further trauma.

6. Techniques in fracture treatment have been spoken of often as: (1) Closed or conservative fracture treatment, or (2) Open or radical fracture treatment. Today, neither should be spoken of as such. So-called conservative treatment can be the most traumatizing, if improperly used, as the open or internal fixation method of applying unnecessary hardware and with too much use of the scalpel. Both methods many times produce more trauma complications than the actual original injury.

7. There is no such condition as a simple fracture. All fractures are either *OPEN* or *CLOSED*, either of which may be a complex fracture. A complex open or complex closed fracture is always where there is severe damage to the bone, the surrounding tissues and other parts involved.

8. Adjust the treatment to the fracture and not the fracture to the treatment. It must be remembered that treatment of a fracture is not just a mechanical problem. It is only one of the many factors which we have to deal with in such conditions. To do any exploration of a fracture just to see what is inside is not any more necessary than the inexperienced general surgeon opening an abdomen to see how the appendix looks, rather than using his judgment, senses, ability to palpate, or use other methods and tests, before any surgery is deemed necessary. The surgeon should develop a sixth sense which comes only by profiting from reasoning and from his experience.

9. Never make a diagnosis as "FUNCTIONAL," nor "NEUROTIC." This is an admission on the part of the doctor that he is not able to make a diagnosis.

10. Traction to the extremities in fracture cases has too frequently been neglected—more so today than ever before.

11. Open surgery, even when meticulously done, should not be done to severely traumatized tissue *JUST TO GET PERFECT BONE APPROXIMATION* at the sacrifice of further soft tissue damage. The blood supply of the damaged tissue must be taken into serious consideration. Mechanical fixation is sometimes necessary but it is not always the *foremost* factor.

12. Perfect apposition is important but, by no means, always necessary in fracture treatment, especially at the expense of more soft tissue damage. A good alignment of a fracture with proper care to the tissues can, in most instances, bring about as good functional results as too much open surgery. More and more experienced leaders in traumatic bone surgery of recent fractures are today eliminating the indiscriminate open reductions of these fractures and their results are definitely far superior, resulting in earlier union, better function, less disability and less infection by treatment of fractures by the closed method.

13. Metal is to be used only seldom in youthful bones, which often causes interference in growth. Application of metal to bone often means subsequent surgical removal, causing further trauma and exposure to potential infection again, whether the patient is an adult, adolescent, or a child.

14. Never depend on antibiotics to cure the sins of poor technique. This is an admission of poor surgical procedures.

15. Unnecessary open surgery with the use of too much metal fixation can be disastrous. This method is not always the quickest and best way for early safe ambulation, good union and recovery. Such technique may cause bad results in the form of non-unions, delayed unions and sometimes infections. There is too frequently a desire to make a robot of the fracture case and we do not desire to make robots of our patients. It often takes a more experienced and dextrous

surgeon to reduce a fracture by closed manipulation than by open operation. Full knowledge of anatomy and the dexterity of the surgeon are fully as important or more important than many procedures done with a knife.

16. In too many hospitals today a closed reduction under fluoroscopic inspection in the Radiology Department (with local or general anesthesia) is so rare that the personnel looks at one in amazement when such a request is made.

17. Advise the patient to return for another visit at least once after the original examination. Often in a patient with multiple injuries you may find further pathology which was not recognized on the first examination. Always take X-rays of the suspiciously injured areas. A superficially injured wrist or other area may be fractured.

18. When over five to six per cent of open reductions of *recent* fractures are done in the average fracture clinic, too many open reductions are being done and any individual surgeon or group of surgeons should stop and evaluate their results on these before continuing to do open operative procedures.

19. The question of time is certainly a great factor in the repair of fractures. Repair has just begun when the wound is closed, or when the cast is applied. Pre- and postoperative observation of circulation of the extremities is imperative!! Neither is convalescence ended when the patient is discharged from the hospital. A surgeon's convalescence care of the fracture case, demands days, weeks, and even months of observation and advice by the surgeon.

20. It is not the most important consideration immediately following an injury to see how early a patient walks, how soon he can get out of the hospital, or how quickly he can get back to work. The rebound is often reactionary and he has to be readmitted to the hospital because of complications resulting in a longer hospital convalescence and care. Often he develops added disabilities which were not directly caused by the injury. Besides, it must be remembered that the patient with a major fracture of the extremities is not going many places regardless of what type of fixation, internal or otherwise, is carried out. The direct point to remember is to treat the patient's injury according to his individual case and not by mass production or law of averages.

21. Perfect bone union is not always necessary if clinical examination shows signs of fair stability as far as weight bearing is concerned. Frequently such cases can be supported in braces so that physical therapy can be used. This stimulates circulation and thereby later can bring about union.

22. If the doctor cannot find the definite cause of complaints from trauma by the patient, even after thorough observation and examination, he should still hold off the diagnosis of a malingering patient, or a psychiatric one, for a while at least and should not put him aside. Be your own psychiatrist. You are supposed to have a few qualifications as such and your patient will develop a confidence in your eagerness to find *positive* or *negative* findings. You will find that the confidence of the patient in you as his surgeon, as it should be, will many times do away with traumatic malingering or psychosis. The compensation case or the automobile liability injury can have just as sincerely real pain from an injury as thousands of household or other types of injuries.

23. Worries and concerns of the patient may become important psychological concerns to him. When the doctor shows unconcern it may cause lack of confidence of the patient in the doctor, or even lack of co-operation in the attitude of the patient. Treatment and attention given at the right time usually prevent major worries

of the patient and doctor with better results. The patient's complaints, both small and large, come first. Treatment of such may prevent untoward *PSYCHOLOGICAL* reactions on the part of the patient.

24. Insurance companies can aid the doctor in alleviating the patient's worries without loss on their part by adjusting their scale of benefit payments to more closely approximate the medical services actually performed by the doctor. There appears to be a need to up-date actuarial tables on which policy premium cost must be based. It is suggested that a study of past case histories be made by an actuary working together with an expert medical authority to establish a more definitive interpretation of the medical language of the case history. This finer definition would then enable the actuary to prepare his charts more accurately by knowing the interpretation which would be made by the insurance company. At present, it seems that the criterion for insurance consideration is a surgical incision. Unfortunately, at times this may influence the surgeon when there is limited benefit coverage for his professional services if no incision is made. This study would diminish the payments on the open operative procedures of fractures and would raise the benefits on treatment of the closed fractures of the complex type. Insurance companies would benefit by being able to show the public a coverage in more direct proportion to the cost of the treatment and would eliminate to a large degree the current complaint that doctors and insurance companies should get together on their charges and coverages.

25. Don't delegate the apparently hopeless cripple to the "ash heap." *While there is life and hope there is rehabilitation!*

26. Too often a new method in the treatment of fractures is hailed, published and put into practice before the wounds may even have healed from such treatment. Time must be allowed for the results to be evaluated. *Too frequently poor results and complications are not reported* from *open fracture treatment* and, if reported, would show the way for less open fracture surgery or show the importance for *improved techniques for such.* Too often a series of a few cases, or even only one case, is reported too early when more time is necessary for decisions to be made. Unusual surgical procedures are acclaimed many times in the press as "successful" within days or even hours of their performance. No serious consideration should be given such reports, not only by the press, but by the medical profession.

27. Alexander Pope correctly stated *"BE NOT THE FIRST BY WHOM THE NEW ARE TRIED, NOR YET THE LAST TO LAY THE OLD ASIDE."* It must be remembered that we should not discard



Yours is an unusual split personality — 10% nice guy, 90% jerk . . .

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that part of the old which has been found good and replace it with the untried or unproven new.

28. Finally—Be ever interested in and dedicated to your profession. You will never want to retire and you will never grow old.

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Graduate Medical Assembly To Convene In New Orleans

The New Orleans Graduate Medical Assembly is scheduled to open its 28th annual meeting at the Roosevelt Hotel on March 8 through 11. Lecturers, symposia, clinicopathologic conferences, round-table luncheons, medical motion pictures, technical exhibits and outstanding speakers will make this an informative conference. The following speakers will appear on the program:

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Robert I. Wise, M. D., Philadelphia, Pa., General Practice.

Curtis J. Lund, M. D., Rochester, N. Y., Gynecology.

S. Gilbert Blount, M. D., Denver, Colo., Internal Medicine.

Jerome W. Conn, M. D., Ann Arbor, Mich., Internal Medicine.

Francis Murphey, M. D., Memphis, Tenn., Neurologic Surgery.

Bayard Carter, M. D., Durham, N. C., Obstetrics.

William F. Hughes, M. D., Chicago, Ill., Ophthalmology.

Milton S. Thompson, M. D., San Antonio, Tex., Orthopedic Surgery.

Benjamin Castleman, M. D., Boston, Mass., Pathology.

Harry C. Shirkey, M. D., Birmingham, Ala., Pediatrics.

This conference is acceptable for twenty-nine accredited hours by the American Academy of General Practice.

For information write: Secretary, The New Orleans Graduate Medical Assembly, Room 1528, 1430 Tulane Avenue, New Orleans, La. 70112.

Cutaneous Larva Migrans and Thiabendazole

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SAMUEL K. MORGAN, M. D., F. A. A. P.

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Cutaneous larva migrans is a cutaneous lesion commonly resulting from the exposure of the unprotected skin of man to filariform larvae of canine or feline strains of A. braziliense, A. caninum and rarely the human hookworms—N. americanus and A. duodenal. It is referred to by a variety of names such as "creeping eruption," "ground itch," "sandworm," etc. This type of hookworm infestation is found along the sandy coastal stretches of the southeastern Atlantic seaboard and around the coast of the Gulf of Mexico and also on the bathing beaches of Brazil and South Africa. Treatment with ethyl chloride spray or CO_2 snow has been most unsatisfactory with regard to administration, acceptability, and cure rate. Recently the systemic use of Thiabendazole as a method of treatment has been advocated and it is the purpose of this paper to record a clinical evaluation of our experience with this medication.

While human strains of ancylostoma produce intestinal infection in man, the feline and canine strains appear unable to negotiate a penetration beneath the stratum germinativum of human skin. When human skin is exposed to moist sand or earth which has been contaminated with infected feces from cats or dogs harboring ancylostoma, the mature filariform larvae in the soil invade the skin producing an itchy, reddish papule at the site of invasion. Usually within two or three days the larvae produce a serpignious tunnel in the stratum germinativum. This lesion is at first erythematous and soon becomes elevated and vesicular. As the larvae move onwards, the abandoned portions of the tunnels become dry and crusty. The movements of the larvae and the tissue irritation give rise to intense pruritis frequently resulting in secondary pyogenic infection. The larvae may continue activity for several weeks or even months but very rarely reach the circulation. The lesions may be single or multiple on any body cutaneous area but most frequently on the hands and feet. Infection is most common during the summer months and during episodes of repetitive shower activity resulting in damp soil conditions.

During May to November, 1964, all patients seen in our routine office practice of pediatrics with clinical evidence of "cutaneous larva migrans" were included in this study. Medication administered was Thiabendazole in dosages of 25 to 50 mgm. per kilo/day in both single and divided doses for varying periods of time (one to three days). These data are summarized in table I. Most patients received 50 mgm/K/D in two or three divided doses which dosage had been found effective in animal experimentations. The patients were examined as to the total number of lesions, those that were active, and the degree of secondary infection present. Concurrent therapy consisted only of medication for secondary infection or non-associated conditions such as anemia.

Side effects were minimal and patient's acceptability to either the oral suspension or chewable tablet was good. Vomiting occurred in four patients receiving the chewable tablets. Rare mild abdominal pain was also encountered but this did not hinder the medication regime. Concurrent laboratory examinations on random patients were performed. Rate of cure with initial course of treatment was both subjective (itching) and objective

(disintegration of larvae), high, above 80 per cent. One patient who had one active lesion remaining after the first course of therapy had the single remaining lesion frozen with CO_2. The remaining six were retreated with complete cure resulting. Apparently the most effective course of treatment in this series was 50 mgm./K/D for 72 hours.

CASE REPORT NO. I: Patient M. O., a nine year old white male, was seen with typical tracts of creeping eruption of seven days duration with symptomatology of constant itching. There was one lesion on the finger and three on the foot. No previous therapy had been given. C. B. C. on first examination revealed: Hgb., 12.7 gms.; W. B. C., 8,800; Eos., 5; Segs., 56; Lymphs., 37; Monos., 2. Stool examination for ova and parasites was negative. He was given Thiabendazole suspension, 50 mgm./K/D in two divided doses for two days. Pruritis ceased after the first dose of Thiabendazole. On examination ten days after treatment, the tracts were entirely cleared and no re-activation had occurred. A repeat C. B. C. revealed: Hgb., 12.7 gms.; W. B. C., 7,250; Eos., 0; Stabs., 2; Segs., 45; Lymphs., 50; Monos., 3.

CASE REPORT NO. II: Patient T. H., a five year old white male, presented with typical tracts of creeping eruptions of seven days duration. These were located on his feet, cheek and ear and followed playing in damp sand. A local antibiotic ointment had been used without benefit. Five areas were active and typical and one suspected but inactive on the cheek. A C. B. C. showed: Hgb., 11.0 gms.; W. B. C., 8,500; Eos., 5; Stabs., 2; Segs., 53; Lymphs., 39; Monos., 1. A stool examination was negative for ova and parasites. He was treated with Thiabendazole, 50 mgm/K/D in three divided doses for two days. All itching stopped just before completion of therapy. When seen ten days after therapy, five of the lesions had completely healed, one had recurred one day prior to followup examination. There was some secondary infection in this area and exact localization for local freezing could not be accomplished. Re-treatment with Thiabendazole in the previous dosage was performed. He was again re-checked ten days later and was entirely well. A repeat C. B. C. showed: Hgb., 11 gms.; W. B. C., 8,200; Eos., 1; Stabs., 1; Segs., 57; Lymphs., 38; Monos., 3.

Summary and Conclusions

Forty-five patients were evaluated using Thiabendazole in the treatment of cutaneous larva migrans to determine its effectiveness. Rate of cure was above 80 per cent with initial course and 100 per cent with a second course. Side effects were minimal. Patient's acceptability was good. It is felt that this drug shows great promise in the treatment of cutaneous larva migrans.

Table I

Initial Course of Therapy

25 mgm./K/D	Single Dose	48 hrs.	72 hrs.
Complete cure	0	2	1
Partial Response	0	0	0
Failure	0	0	0
50 mgm./K/D			
Complete cure	1	25	9
Partial Response	0	3	0
Failure	1	3*	0

(*2 failures resulted from inability to retain wafer)

Retreatment Course

50 mgm./K/D			
Complete cure	1	5	0
Partial Response	0	0	0
Failure	0	0	0

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Recent Advances in Study of Rheumatic Diseases: Analgesic Nephropathy

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An ever-increasing literature has appeared in the past decade pertaining to the abuse of analgesic compounds containing phenacetin and the propensity of this abuse to produce serious renal disease. The problem is not rare as is manifest by the mass of literature and the number of cases reported both abroad and in this country. Increasing concern has led to restrictions on sale of analgesics containing phenacetin in Sweden while FDA regulations in this country now require warning labels on all phenacetin-containing drugs.

Phenacetin's culpability has been correlated with its ubiquity in the compounds abused as well as its known capacity to produce other toxic manifestations, notably in the red blood cell (methemoglobinemia, sulfhemoglobinemia, anemia) and the central nervous system (headache, tremor, emotional lability, irritability, twitching, confusion and insomnia).

Recent findings, though, have tended to broaden somewhat the etiologic spectrum. It is important to be aware of the nephrotoxic capacities of phenacetin and other analgesics as well as the parameters of the entity of analgesic nephropathy itself.

In 1953, Spuhler and Zollinger[1] first described serious renal disease occurring in patients who had consumed inordinately large amounts of various analgesic compounds, all of which contained phenacetin as one of the ingredients.

From the Division of Rheumatic Diseases, Department of Medicine, University of Alabama Medical Center, Birmingham, Alabama, made possible by NIH TI AM 5000-10 and Merck, Sharp & Dohme, West Point, Pa.

The kidneys of these patients were described as being pale, variably normal or contracted in size, with a loss of corticomedullary demarcation. Necrosis of the renal papillae, either macroscopically or microscopically, was frequently noted. Histologically, the interstitial tissues were moderately infiltrated with chronic inflammatory cells in the transition zone between cortex and medulla. The tubules were badly damaged and surrounded by fibrosis. The glomeruli and renal vessels were usually spared. Others[2] commented on the findings of abundant lipofuscin pigment within the epithelial cells as well as thickening of the tubular basement membranes in their biopsy specimens of analgesic nephropathy. This basement membrane thickening was more severe in the distal tubules and on electron microscopy was seen to contain interfibrillar granules. They offered these findings as more evidence for a specific analgesic-induced lesion. Distinguishing analgesic nephropathy from chronic pyelonephritis may prove very difficult and, when supervening infection occurs, may be impossible.

After the first few reported cases, a burgeoning number of similar case reports appeared, at first in the foreign literature and more recently in this country. Most authors condemned phenacetin abuse as the etiology of the renal disease found in their patients. It was concluded in one study[3] that consuming five to seven phenacetin containing tablets per day (approximately one gram phenacetin) for a period of 10 years would result in an 80 per cent chance of reduced renal function and that practically all patients who had consumed seven kg of phe-

nacetin or more would have reduced renal function.

It is of note that phenacetin was combined with other analgesic or anti-inflammatory drugs in all preparations associated with nephropathy and that there has been no example of human renal disease reported with pure phenacetin ingestion only. It is of further interest that the percentage of impurity, particularly acetic-4-chloranilide, present in these compounds has not been uniformly reported. This impurity results from the manufacture of phenacetin from 4-nitrochlorobenzene and may be of major importance epidemiologically.[4]

Other analgesic drugs' nephrotoxic capacities need to be assessed more definitively. Clausen and Harvald[5,6] demonstrated a urinary sediment increase in leucocyte and erythrocyte count in patients treated for short periods with five different analgesics, including phenacetin, phenacetin contaminated with acetic-4-chloranilide, acetylsalicylic acid, phenylbutazone, and acetanilid. "Surprisingly" they found that acetylsalicylic acid caused a far greater irritation than any of the other compounds. Phenacetin contaminated with acetic-4-chloranilide was a somewhat distant second to salicylate in this regard but was far more potent an irritant than the other three drugs tested.

Clausen[7] demonstrated lesions similar to, but not identical with, human analgesic nephropathy by feeding phenacetin and acetylsalicylic acid to separate groups of rabbits. These changes developed independently of bacterial infection and utilized a dosage that would correspond to an intake of seven kg in a 60 kg man which is not an unusual amount taken by many people in whom renal impairment has been demonstrated.

Harvald[8] reported a series of cases of renal papillary necrosis in which one patient had taken acetylsalicylic acid only. Another had been treated intensively with para-aminosalicylic acid which may be equivalent to acetylsalicylic acid in nephrotoxicity.

Acetominophen[9] may be able to induce interstitial nephritis in the rat as well as decreased urinary concentrating ability but no conclusive evidence has as yet been presented.

The capabilities of other drugs contained in these analgesic compounds to produce interstitial nephritis and papillary necrosis has not been experimentally determined. If the phenacetin in these compounds is being abused, then by necessity of combination so are caffeine, codeine, antipyrine, barbiturates, or whatever drug or drugs that have been combined with phenacetin. The evidence against phenacetin is impressive and probably denotes a causative role but the possible causative or synergistic potentials of other drugs contained in these mixtures is yet to be ascertained. Salicylates certainly bear more scrutiny but the fact that salicylates are not common to all the mixtures that have caused analgesic nephropathy would necessitate exclusion from full responsibility. The conclusions that would seem to be justifiably drawn at this time are that abuse of an analgesic compound is common to all cases of nephropathy and that at least one drug in the compound possesses anti-inflammatory properties.[10]

The mechanism of analgesic nephropathy is not fully known at the present. Experimental and clinical evidence would seem to favor a direct long-term biochemical toxicity.[2,11,12] The presence of an anti-inflammatory agent in all the preparations might mean interference with normal defense mechanisms and increased susceptibility to infections[10] but the frequent finding of sterile urine with pyuria[11,12] would tend to be in favor of direct toxicity to renal tissue rather than active infection.

Numbered among drug effects that may be of nephro-toxic significance are the production of sulphemoglobin, methemoglobin, hypokalemia, renal ischemia and anoxia, hypersensitivity and hemosiderosis.[10] Which of these, if any, are of major importance is not known at the present.

The clinical course[11,12] of analgesic nephropathy is usually that of slowly progressive renal failure. The clinical picture at any

one time may vary over a fairly wide range depending on the stage of involvement present in the particular patient.

The onset is insidious, with loss of ability to concentrate the urine, polyuria and polydipsia early manifestations. The course of the disease may be punctuated by bouts of metabolic acidosis. Papillary necrosis is a frequent occurrence and may bring the patient to the physician with hematuria and flank pain. A necrotic renal papilla may be found in the bladder or obstructing the ureterovesical junction. Contrast radiography[13] may show filling defects consistent with a necrotic papilla loose in the calyx, may demonstrate cavities within one or more papillae or may reveal both abnormalities.

The urinary sediment will frequently show pyuria without bacteriuria. Proteinuria is usually a late manifestation, as are hypertension and azotemia.

Extrarenal manifestations are frequent and may include anemia (almost all patients are anemic), neurologic signs, gastrointestinal symptoms and skin discoloration. Sulfhemoglobin or methemoglobin levels may be elevated.

The best diagnostic tool is the history of excessive ingestion of analgesics but these patients tend to be reticent or even secretive concerning such consumption. Their motives for taking these compounds are varied but most patients gave pain, particularly headache, as the major reason; although in one well studied group[14,15] the drug was taken to increase productivity in a group of factory workers. Considerable skill is usually necessary to elicit the history and often the physician may have to rely upon friends or relatives to confirm his suspicions.

Patients with chronic renal failure of uncertain origin, particularly those with anemia or history of severe headaches should be questioned carefully regarding analgesic intake for, upon withdrawal of the analgesic, stabilization of the disease or even remission may occur.[11,12]

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New Drugs and the Practicing Physician

The conditions of practice are different from the conditions of the research ward, and the trial the drug undergoes at the hands of the practicing physicians is more stringent than anything that has gone before. Thus, the conditions of practice will uncover weaknesses in the patients treated which are vulnerable to the effects of particular drugs and which, because they had not been reported before, might be labeled as "unusual" reactions.—Harry F. Dowling, M. D., in *Maryland State Medical Journal,* 13: 12, (Dec.) 1964.

President's Page

"Everyone predicts that the 89th will write Medicare into law" . . . . "Many have overlooked the possibility that the inclusion of Medicare as a part of the established social security system could **imperil the reserves** held in that system—reserves already regarded as dangerously slim." "As the appreciation of this threat grows—watch for moves to **segregate** the medicare tax from the social security system as now set up." "It may be front page news by summer." This is quoted from Babson's Reports, Washington Forecast Letter, dated January 4, 1965.

We have already stated that LBJ was sending up trial balloons regarding the possibility of a separate tax. This was in December, 1964. Rep. Wilbur Mills of the House Ways and Means Committee stated in a speech before a Lion's Club in his home state that he would be agreeable to a separate tax for health care for the aged administered by Social Security. Government clerks are being told that jobs will be available in such an organization in the near future. Civil Service employees, who are being "phased out" because of the reduction in Army Corps Headquarters and Army Reserve units, are being told such jobs will accommodate them.

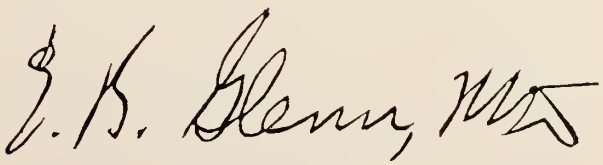
It seems a foregone conclusion that Health Care for the Aged under Social Security will pass this Congress. The rules of the House are being changed to prevent the Rules Committee from holding up legislation too long. The House Ways and Means and Appropriation Committees are being recognized along party lines to prevent them from obstructing passage of so-called "liberal legislation." "The erstwhile conservative coalition (Republicans and Conservative Democrats) will **no longer** be a bar to liberal legislation."

This means that that "compromise" of which we have been warned might be reached now seems the order of the day in Washington. This even "smacks" of clever strategy. Since a separate fund must be set up to save Social Security from bankruptcy, (this was organized Medicine's best argument against the old King-Anderson Bill—there is a new one now), everyone will be subscribing to **COMPULSORY HEALTH INSURANCE.** The employer must pay part of the premium as well as the employee. Sooner or later, the employer will be paying it all as in so many package deals that are being pushed by the AFL-CIO. The younger employee will demand that his rate be cut because the older employees, already close to retirement, will get the most benefit earlier. The younger employee will then demand that someone else pay the bill.

With a form of compulsory health insurance thus established, it will not be long before it will be universal for the entire wage-earning group. The "foot in the door" will have been accomplished. The headline, "British Medics Call 'Cradle to the Grave' A Mess" (Chicago American, Sunday, December 13, 1964) clearly expressed what we will have on our hands in this country.

There are only 278,000 physicians in the United States. The hospital facilities throughout the nation are taxed to capacity. Plans for expansion of medical schools and para-medical teaching facilities are under way. There is a "population explosion"; people are living longer because of miraculous advances in medical knowledge, and their demands for "full coverage" are sending this civilization ahead faster and faster.

May we learn to slow down and consolidate our gains, then move ahead on a better give-and-take basis. Is compulsory health insurance the way to do it?





UNBROKEN RECORD OF DEDICATION TO SICK

The University of Alabama Hospitals and Clinics continued an unbroken record of dedication to the care of the sick and injured of the community, the State and the entire Southeast during the 1963-64 fiscal year, according to General Director Matthew F. McNulty, Jr.

The most dramatic advancements in expansion and modernization of facilities in the history of the institution, coupled with the ever-increasing activities of service, education, research, rehabilitation and prevention, retained for this acute general Hospital the position of one of the top 30 hospitals in the nation in volume of services rendered, and again ranked it as the State's Number One referral center.

According to Director McNulty, a program of expansion and modernization is being followed which will lay a firm foundation for the health needs of future generations. Construction activities underway or recently completed by the University of Alabama Hospitals and Clinics approximate more than $12,436,000.

The 46-bed inpatient and large outpatient Spain Rehabilitation Center was dedicated in April, 1964. The 60,000 square foot structure was built at a cost of $1,732,000 of which $550,000 was made available by donors.

Construction of a 100-bed Psychiatric Wing with supporting facilities at a cost of $4,204,000 began in July, 1964. The building will have seven stories and a basement and will tie in on all floors to the main University Hospital. Four floors will provide adult, pediatric, gerontological and research psychiatric beds and supporting facilities, fifteen (15) new Operating Rooms, another floor a new Diagnostic Radiology activity, the ground floor a new Greater Birmingham Emergency Clinic, and the basement will be a Supply Area. It is expected that the building will be completed in early 1966. Funds for the program came from a $3,000,000 bond issue and $1,204,000 in Hill-Burton monies. The new Psychiatric Wing is to occupy the site of the former Outpatient Clinic Building.

To house the Clinics, University Hospital purchased and renovated a 42,000 square foot building located across the street from the main Hospital Complex. This new building was activated during the 1963-64 fiscal year as the University Hospital Outpatient Services Building. The purchase price of the building was $400,000. The renovation cost was $360,000 with the funds secured largely by loan. All the out-patient clinic activities with the exception of Psychiatric Clinic have been consolidated in this new building.

A former 7-story Nursing Student Residence, vacated by the 1963 construction of the University Hospital Nursing Residence, is now being remodeled and has been designated the University Hospital Clinical Serv-

ices Building. This renovation is at a cost of approximately $1,300,000. The facility will house Surgical Pathology, Clinical Laboratories, A Core Laboratory for the Clinical Research Unit, part of the Medical Records and Student Health. The renovation is being financed by $685,000 in Accelerated Public Works monies; $225,000 from the National Institutes of Health; and a loan of $427,000. Occupancy of the Clinical Services Building is anticipated in the near future.

The Smolian Psychiatric Clinic of the University Hospital, previously a two-story structure, is now having two floors added at a cost of $300,000. A donor contributed $100,000 which was matched with $200,000 in Hill-Burton funds. It is expected that the construction will be completed by early 1965.

A proposed South Wing Addition to the University Hospital Building is on the drawing boards. This 7-story addition would cost approximately $4,000,000 and would improve existing bed space as well as kitchen and cafeteria facilities. Funds are now being sought and preliminary plans considered.

Patient care combined with education continued to be the primary goal of the University of Alabama Hospitals and Clinics in 1963-64, according to McNulty. Patients discharged totaled 23,259 of which 3,859 were newborn admissions—a slight decrease from the 4,038 births of the previous year. They represent admissions from all Alabama counties, 23 other States and 3 foreign countries. A daily average of 541.79 patients, including an average of 35.12 newborns, was maintained by this 600-bed institution which also recorded 198,294 days of care to patients during the 1963-64 fiscal year. The average length of stay per patient was 8.51 days.

Visits made to the thirty-one University Hospital Outpatient Clinics totaled 51,191—a sharp decrease due to the initiation of a fee-for-service program which was necessitated because of the lack of sufficient funds for operation.

An increase of 8% was reported by the Radiological Service of the Hospital, which, combining therapeutic X-ray treatments, radioisotope treatments, and diagnostic examinations, reported 88,780 treatments in 1963-64 over last year's 82,187 treatments.

The Clinical Laboratories experienced a 7.3% increase in number of laboratory determinations with a total of 880,703 tests in 1963-64 over 820,069 in 1962-63.

Also reporting increased services was the Department of Physical Therapy whose number of treatments totaled 22,059 over the previous year's total of 21,134 treatments—an increase of 4.3%.

In its first year of operation, the Occupational Therapy Department of the Hospital recorded 1,155 treatments.

In addition to the equipment and facilities, the services of more than 1,700 employees and almost 450 members of the medical staff were utilized to provide patient care.

Retaining its high standing as an educational institution, University Hospital continued operation of its nine fully-accredited paramedical schools and auxiliary teaching programs with student enrollment as follows: School of Anesthesia for Nurses, 15 students; School of Blood Bank Technology, 3 students; School of Cytotechnology, 4 students; Dietetic Internship, 8 students; School of Laboratory Assistants, 5 students; School of Medical Technology, 11 students; School of Nursing, 197 students; School of Physical Therapy, 3 students; and School of Radiological Technology, 14 students.

Participants in the University Hospital Medical and Dental Intern and Residency Programs total 44 interns and 145 residents.

Continuing efforts in the field of research are evidenced by the Hospital's operation of the Clinical Research Unit and the Artificial Kidney Unit.

Already at an all-time peak in service, the Hospital pledges, according to Director McNulty, "continued advancement for the health of the Statewide community."

LET SOCIAL SECURITY FULFILL ITS PROMISES

The Social Security system should make good on previous promises before it is expanded to include such items as "medicare," the nation's independent business proprietors feel.

This viewpoint of the independent business reflected by their various votes is part of the information sent by the National Federation of Independent Business to the nation's high school and college economic instructors, C. Wilson Harder, president, reports.

Pointing out that today's maximum pension will not buy the same amount of food the maximum benefit promised in 1937, Harder states that the system is failing to fulfill its original primary obligation, that of providing sustenance for the aged.

He also pointed out that while a retired person over 65 can have unlimited income from investments and other sources and draw the full pension amount, this privilege is denied to those who must supplement with some sort of employment. This he terms as class legislation attempting to attain social goals not compatible with the operation of a bona fide insurance plan.

He points out too that the method of loaning out Social Security reserve funds at a low interest rate averaging only 3% is quite unrealistic. He urged educators to encourage today's students to make a careful study of the Social Security system and to take steps to make their opinions known. He states that while relatively few adults now living will be contributing to Social Security for the full term of 40 or more years, the full burden will be borne by today's students, and thus they should know, understand, and approve of the burden they wish to assume in this respect.

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145 MILLION PROTECTED BY HEALTH INSURANCE

Health insurance protects 48 million more Americans today than it did 10 years ago, the Health Insurance Institute reports.

Ten years ago, over 97 million Americans were covered by hospital expense insurance. Since then there has been a coverage increase of nearly one-and-one-half times, and a total of over 145 million persons were protected against the cost of hospital care at year-end 1963, declared the Institute.

In 1953, 61 per cent of the U. S. civilian population was protected by some form of health insurance, the Institute said, while at the beginning of this year 77 per cent was so insured.

The same type of growth has been shown, said the Institute, by other forms of health insurance.

In 1953, nearly 81 million Americans had surgical expense insurance, but in the following 10 years there was a 67 per cent increase in this coverage and at the end of 1963 nearly 135 million persons had protection against the cost of surgical bills.

Regular medical expense insurance covered nearly 43 million Americans in 1953. However, there was a coverage increase of more than two times in ten years so that more than 102 million persons were insured last year.

Original Paintings Sought

A long-range plan to create a collection of original paintings of the medical colleges of America is being sponsored by E. R. Squibb & Sons. There are, at present, 83 accredited, four-year schools of medicine in the United States.

COLLEGE OF PHYSICIANS NOTES ANNIVERSARY

The Golden Anniversary Session of the American College of Physicians (ACP) will be held in Chicago, March 22-26, at the Conrad Hilton Hotel. Highlights of the meeting will be presentations by prominent internists who received top awards from ACP in 1933, 1949 and 1957 and an emphasis on the relationship of psychiatry to internal medicine.

Some 300 physicians and other medical scientists, including two from Norway and Switzerland, will take part in the five-day scientific program.

Internal medicine specialists attending the session will receive reports on late developments in the diagnosis and treatment of diseases via plenary sessions, panel discussions, lectures in basic medical sciences and clinical investigation and closed circuit television programs. On two mornings, the physicians will attend special clinics in Chicago hospitals.

During the opening plenary session on Monday, March 22, the ACP President—Thomas M. Durant, M. D., of Philadelphia—will present a historical review of the College and of the progress in internal medicine since its founding in 1915.

PRESIDENT SUCCESSION PLAN OFFERED BY CED

New provisions for quickly transferring the duties and powers of the Presidency in the event of the death or inability of the President, and to assure that the United States is never without a Vice-President ready to assume Presidential responsibilities, have been proposed by the Research and Policy Committee of the Committee for Economic Development (CED).

"The urgency of national action to resolve the doubts and uncertainties clouding Presidential succession and inability cannot be overstressed," the CED statement on national policy says. "Failure to correct the deficiencies will subject the nation to risks and hazards that are avoidable. Prompt action is imperative . . . The United States of America must have one person wielding the powers and duties of the Presidency at all times."

To make certain that this condition prevails, the Committee offered two major proposals:

(1)—Amending the Constitution to provide that any vacancy in the office of Vice President be filled by giving the President authority to nominate a Vice President subject to approval by joint session of Congress.

(2)—Placing in the hands of the Cabinet authority to decide the beginning of Presidential inability, the Vice President concurring. The ending of inability should also be determined by the Cabinet, with the President confirming.

ROME SITE OF SEMINAR ON LEGAL MEDICINE

A group of prominent physicians and attorneys from several cities are planning an international seminar on legal medicine, to be held in Rome beginning February 26th.

More than 130 will participate in the international conference, most of them flying to Rome on a chartered DC-8 jet.

Dr. Cyril H. Wecht, director of the Pittsburgh Institute of Legal Medicine, extended an invitation to attorneys and physicians who may be interested. Dr. Wecht, a physician-attorney, founded the Institute several years ago.

To be conducted in conjunction with the Medical-Legal Institute of the University of Rome, the seminar will examine the entire area in which the fields of medicine and law coincide.



Medical Self-Help

If Disaster Strikes . . . And There Is No Doctor

Without the help of doctors and nurses how would people treat injuries, care for the sick and consequently save lives? This question looms importantly when the likelihood is accepted that professional medical help probably would not be available for two weeks or more in case of a nuclear attack on the United States.

Of course a nuclear war is not expected. But if one should occur it is obvious that people will have to help themselves and others when there will not be enough doctors and nurses to give the professional help they are used to getting.

In addition to the nationwide fallout shelter program Federal and State governments are undertaking, a medical training program is now underway to teach people the many things they would have to do in such an emergency to care for the injured, the maimed and the sick.

The Medical Self-Help Course, as the program is called, is designed to give basic information and some skills in treating injuries to the people of this country that will help prepare them to survive during a national disaster when physicians will not be there to help.

In a nuclear attack buildings, machines, factories, powerlines, etc., would be destroyed. These things could be replaced. Individual Americans could not. Experts agree that even a really massive attack with nuclear bombs would not kill everybody. Perhaps a majority of the people would survive. Medical Self-Help can provide the necessary knowledge to enable people to maintain health without medical help during the two or three critical weeks following a nuclear catastrophe.

The Medical Self-Help program has been in existence for about three years. It is a cooperative effort of the Office of Civil Defense, the U. S. Public Health Service, and the Council on National Security of the American Medical Association. However, individual States are responsible for administering the program. In Alabama the Health

Mobilization Section of the State Health Department is promoting Medical Self-Help training in the state through the County Health Offices.

The national goal of Medical Self-Help is to train at least one member of each family in the U. S. in the basic principles of emergency medical treatment and care. According to Max G. Cain of the Health Mobilization Section, 26,000 people have already completed the program in Alabama since it began in March, 1962. The course is now being conducted in public and parochial schools in 63 of Alabama's 67 counties. This includes the University of Alabama and six colleges within the state. Also, many government agencies, like the Veterans Administration, the Social Security Administration district offices, Maxwell and Gunter Air Force Bases, are giving the course. Private industry, civic clubs and other colleges throughout the state have also indicated strong interest in the program. Mr. Cain estimates that 30,000 Alabamians are currently participating in Medical Self-Help training. The course does not have to be taught by a physician. It is taught, under the guidance of a physician, by teachers, office supervisors and other lay instructors who have been given preliminary instruction and who utilize a comprehensive instructors guide which is included in the training kit provided for each group taking the course. Students are given a detailed students manual to study and which also serves as a future reference guide for practical use.

At the beginning and throughout the course, it is impressed upon the students that Medical Self-Help is **not** a substitute for professional care and is not to be used except where it is required to save lives when doctors and nurses are not available. Students are taught how to treat symptoms only.

This is the basic theme of the program. Self-Help training can and does teach people how to care for themselves and others when professional medical help cannot be expected for an extended length of time. In this way it complements First Aid treatment.



The course consists of 11 lessons that require about 16 hours of instruction. Subjects taught in the course include radioactive fallout and shelter, healthful living in emergencies, artificial respiration, bleeding and bandaging, fractures and splinting, transportation of injured, burns, shock, nursing care, infant and child care, and emergency childbirth.

Students completing the course should have acquired enough skills to restore breathing by artificial respiration, stop severe bleeding before it is fatal, recognize and treat fractures and dislocations with improvised splints, treat shock and burns and finally give long-term care of injuries to patients after the emergency treatment has been given.

Knowledge replaces fear is a trusim we all accept. Medical Self-Help hopefully will be able to give enough people the basic survival knowledge we have been discussing so that following a massive disaster many lives that would otherwise be lost will be saved.



A medical scholarship bill and comprehensive reports on legislation under consideration for 1965 occupied the attention of the Committee on Legislation at a meeting January 17, 1965 at MASA headquarters. Dr. William B. Virgin (extreme right) is chairman of the Committee. Shown (from left) are: Drs. W. E. White and Paul Burleson. With backs to camera are Dr. Luther Hill, left, and Dr. Ira Myers. Hidden behind Dr. Hill is Dr. John Chenault.



MASA's Committee on Constitution and By-Laws gave a thorough study to the Association's organic laws at a day-long session held at headquarters January 17, 1965. Shown at work are, left to right, Dr. Hal Ferguson, Dr. Luther Hill, Dr. J. A. Pennington and Dr. William L. Smith, Association secretary.



The Committee on Aging and Indigent, meeting January 17, 1965, at MASA headquarters, is shown receiving a report from the chairman, Dr. J. Garber Galbraith, on a recent meeting in Chicago aimed at implementing the Kerr-Mills program in the states. Shown, left to right, are Drs. Buris Boshell, J. J. Kirschenfeld and Ira Myers, State Health Officer. In picture below, Dr. Galbraith is shown making his report on Alabama's handling of Medical Assistance to the Aged (MAA) program to a group in Chicago.



SOUTHERN MEDICAL UNITS ANNOUNCE NEW OFFICERS

The Section on Industrial Medicine and Surgery of the Southern Medical Association has elected the following officers to serve for the coming year: H. Charles Ballou, M. D., White Sulphur Spring, W. Va., Chairman; W. G. Thuss, Jr., M. D., Birmingham, Chairman-Elect; and Dabney M. Ewin, M. D., New Orleans, Secretary.

The Association's Section on Neurology and Psychiatry elected: Robert A. Utterback, M. D., Memphis, Chairman; James N. Sussex, M. D., Birmingham, Chairman-Elect; William F. Sheeley, M. D., Washington, D. C., Secretary.

The Section on Physical Medicine and Rehabilitation elected: Frank J. Schaffer, M. D., Washington, D. C., Chairman; Claude W. Garrett, Jr., M. D., New Orleans, La., Chairman-Elect; and William C. Fleming, M. D., Birmingham, Secretary.

around the state

MISS LANGSTON DIRECTS HEALTH CAREERS COUNCIL

Miss B. Parnell Langston has been named program director of the Health Careers Council of Alabama effective February 1, 1965.

The Council is a new non-profit organization which will expand and coordinate activities in the area of education about health career opportunities and recruitment of people into health careers and health work. Offices are in Birmingham.

The Council has been endorsed by all major health organizations and will be conducted as a program of the Alabama Hospital Association Research and Education Foundation, Inc.

Miss Langston has served as assistant to the general director of the University of Alabama Hospitals and Clinics and has had extensive work experience in the health field.

Membership of the Health Careers Council of Alabama includes three physicians: William L. Hawley, Julian S. Lewis, and George F. Scofield, all of Birmingham; three hospital administrators, John L. Howell, Birmingham, D. O. McClusky, Jr., Tuscaloosa, and James E. Crank, Birmingham; one nurse, Mary Catherine King, R. N., Birmingham; one public education representative, Clifton Nash, Montgomery, and an industrial representative, Harlon Prater, Fayette.



A father-son combination are the Drs. Gerald G. Woodruffs, junior (left) and senior (right), shown during a recent medical-surgical seminar at Anniston, where both practice medicine. With them (in center) is Col. George Lull, Jr., commander of Noble Army Hospital at Fort McClellan. The elder Woodruff commanded a 1,000-bed hospital in France during World War I; his son served for a year in Korea. Both are graduates of Tulane.

Society For Sterility Study Will Meet In San Francisco

The American Society for the Study of Sterility, with offices in Birmingham, announces plans for their Twenty-First Annual Meeting to be held April 2, 3 and 4, 1965 at the Jack Tar Hotel in San Francisco. The tentative program includes luncheon seminars, clinical-research "correlars," scientific papers, technical exhibits, and open discussion panels, as well as many social features.

Registration applications should be directed to: William H. Robertson, M. D., Registration Chairman, 2700 Tenth Avenue South, Birmingham, Alabama 35205.

BRIEFS

The Madison County Medical Society reports an obstetric clinic for low income and indigent persons will be opened in Huntsville this month. Each patient will be charged a fee based on his income with free service offered to those with no income. Huntsville doctors will volunteer their time on a rotating basis.

* * *

Dr. Gilbert Melson, of Florence, will serve as Lauderdale County's March of Dimes Director for 1965.

* * *

Largest single contribution to the 1964 fund raising program of the Society for Eradication of Tuberculosis in the Wiregrass (SETWIRE) came from the Pike County Medical Society. The Society emphasized that the $200 contribution was a part of the funds collected in the mass polio immunization program last year.

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Dr. Edward F. Crippen has been named Health Officer for Mobile County.

* * *

Dallas County Health Department will begin making available oral polio vaccine for persons unable to purchase it, according to Dr. James S. Ross, county health officer.

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Dr. Lehn L. Parker, of Andalusia, was the victim of an automobile accident on Christmas Eve. His injuries were reported, "painful but not serious."

* * *

The Athens Clinic is building two suites of offices, one to provide space for a pediatrician and the other for a surgeon. Dr. David E. Bowers, native of Birmingham, and graduate of the Medical College of Alabama, will occupy the pediatrician's suite. Dr. Henry H. Pendleton, practicing surgeon at Athens for the past seven years, will occupy the surgeon's suite.

* * *

Dr. Julius Michaelson of Foley, president of the American Academy of General Practice, and Dr. James Duke of the Mobile General Hospital, were guest speakers at the kick-off drive of the Baldwin County March of Dimes, at Fairhope.

* * *

Madison County Medical Society has opened a permanent office to help newcomers to that city to find a family physician. Sponsors said that while the office would not solve the doctor shortage in the Huntsville area, it is designed to "steer a person in the right direction." New residents are being urged to select their family doctor before they become ill.

* * *

Dr. Buris R. Boshell, chief of the medical service at Veterans Administration Hospital in Birmingham and professor of medicine at the Medical College of Alabama was principal speaker at a joint meeting of the medical societies of Morgan, Limestone, and Lawrence counties January 5, 1965. Dr. Boshell received his M. D. degree in 1953 from Harvard Medical School after spending his first two years at the Medical College of Alabama.

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Construction has begun on a $50,000 clinic at Brewton to contain physician and dentist offices. The builder is Dr. Herman C. Wood.

* * *

The Jefferson County Medical Society will host a meeting in Birmingham March 29, 1965, at which Dr. Donovan C. Ward, president of the American Medical Association, will be principal speaker.

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Dr. Robert I. Westbrook, formerly of Shreveport, Louisiana, has joined the staff of the Luverne Medical Clinic. Dr. Westbrook played varsity football at Tulane for three years, later obtaining his M. D. degree at Louisiana State University.

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The Pike County Medical Society, at its January meeting, was shown a film "Medical Effects of the Atomic Bomb" by R. L. Farris, county coordinator for Civil Defense.

MEDICAL COLLEGE PRESENTING 'PROGRESS IN GYNECOLOGY'

The Division of Continuing Medical Education, University of Alabama Medical College of Alabama, Birmingham, will present a course in "Progress in Gynecology" February 18-19.

Registration fee is $30. The course is accepted for 12 hours credit by the American Academy of General Practice.

Guest speakers include: Frederick P. Zuspan, M. D., professor and chairman, Department of Obstetrics and Gynecology, Medical College of Georgia, Augusta, Georgia; Fred J. Hofmeister, M. D., Clinical Professor of Obstetrics and Gynecology, Marquette University School of Medicine, Milwaukee, Wisconsin; Charles W. Neville, M. D., Chairman, Education Committee, Alabama Academy of General Practice, Birmingham.

Dr. W. N. Jones, professor and acting chairman of the Department of Obstetrics and Gynecology at the Medical College of Alabama will moderate the first session; Dr. Edwin G. Waldrop, Clinical Assistant Professor of Obstetrics and Gynecology will be coordinator of "Laboratory Demonstrations and a How-to-do-it Clinic; Dr. Walter P. Batson, clinical instructor in Obstetrics and Gynecology, at the Medical College will moderate the third session on Friday morning; and Dr. Neville will moderate the Friday afternoon session.

The Division has seen fit to cancel the original course on "Current Concepts in Pulmonary Diseases" and will reschedule it for the Fall session. The following courses have been scheduled for the Spring period: March 31-April 1, "Pediatric Problems, Common and Complex"; April 16-17, "Tropical Medicine"; May 20-22, "Three Days of Cardiology."

Lederle Symposium Planned For Montgomery February 26

The Montgomery Chapter of the Alabama Academy of General Practice and the Alabama Section of the International College of Surgeons will hold a one-day symposium on "Practical Medical and Surgical Problems" on Friday, February 26, 1965 at the Jefferson Davis Hotel in Montgomery.

Speakers at the morning session will be: Dr. David M. Bosworth, professor and director, Orthopedic Surgery and Traumatic Surgery, New York Polyclinic Medical School and Hospital, New York City; and Dr. John H. Killough, Jefferson Medical College of Philadelphia, Pennsylvania. Afternoon speakers will be Dr. Jeanne C. Bateman, clinical instructor in medicine, George Washington University School of Medicine, Washington, D. C., and Dr. Manuel E. Lichtenstein, Chicago.

Dr. Julius Michaelson, president of the American Academy of General Practice of Foley, Alabama, will be the luncheon speaker.

New Color Slides Offered By College Of Radiology

The American College of Radiology has a new slide series available, "The Production of X-rays and the Interaction of Radiation and Matter."

The slides are in color and have an illustrated explanatory brochure. They are aimed at teaching the fundamentals of x-ray theory to groups such as radiology residents, x-ray technicians, research assistants and medical students.

The 30 color slides plus the accompanying commentary is available for $7 from the American College of Radiology, 20 North Wacker Drive, Chicago, Illinois.

February 28th Deadline For Ob-Gyn Applicants

Applications and letters of request from previous applicants requesting to be scheduled for the forthcoming Part I examination of this Board to be given July 2, 1965 will be accepted in the Board office up until the closing date of February 28, 1965. Applications and letters of request postmarked after that date will be returned to the sender.

Application forms and Bulletins may be obtained by writing to the office of the Secretary—Clyde L. Randall, M. D., American Board of Obstetrics and Gynecology, 100 Meadow Road, Buffalo, New York 14216.

Servicemen applying for the Part I examination are requested to submit the name of their Commanding Officer.

Diplomates of this Board are requested to keep the Board office informed of address changes.



The wife is making out fine with her diet. Last week she disappeared completely.
Nebraska Medical Journal

Academy Foundation Plans First Family Health Forum

Some provocative answers to many questions concerning future medical care of the American family are expected to come from the first national meeting of the National Family Health Conference which is being sponsored by the American Academy of General Practice Foundation on Friday, April 9, 1965 in San Francisco. The conference is being held at the Fairmont Hotel the day prior to the opening of the Academy's Congress of Delegates.

This conference will be the first such consultation forum sponsored by the Foundation which was established in 1958 to promote and maintain high standards of practice in medicine and surgery. There will be four speakers on the morning session, and four in the afternoon, with question-and-answer periods following each session.

Conference On Rural Health At Miami Beach March 26-27

The 18th National Conference on Rural Health sponsored by AMA Council on Rural Health will be held at the Americana Hotel, Miami Beach, March 26-27. Among the purposes of the conference are to discover and be able to implement the utilization of community health resources and to improve methods of communication in health education for rural people.

Speakers include Joseph F. Volker, D. D. S., Vice-President for Health Affairs, University of Alabama Medical Center, Birmingham, and E. Neige Todhunter, Ph. D., Dean, School of Home Economics, University of Alabama. Edward R. Annis, M. D., Immediate Past President, AMA, will be the banquet speaker.



The Joint Council to Improve the Health Care of the Aged met January 17, 1965, at MASA headquarters with Dr. J. J. Kirschenfeld of Montgomery, presiding. The Council, composed of the several state organizations concerned with care of the aging, heard reports on progress in this field. Shown above are, left to right, B. J. Russell, executive secretary, Dr. Polly Ayers and Dr. Tom Wheeler, representing the Alabama Dental Association, Miss Catherine Corley, Alabama Nurses Association, Homer Gattis, North Central Chapter, Alabama League of Aging, and C. A. Strong, president, Alabama Pension Institute, Inc.

Practical Medical, Surgical Seminar Scheduled February 26

The Montgomery Chapter of the Alabama Academy of General Practice and the Alabama Section of the International College of Surgeons will hold a one day symposium on "Practical Medical and Surgical Problems" for Friday, February 26, at the Jefferson Davis Hotel in Montgomery.

Speakers at the morning session will be Dr. David M. Bosworth, professor and director, Orthopedic Surgery and Traumatic Surgery, New York Polyclinic Medical School and Hospital, New York City and Dr. John H. Killough, Jefferson Medical College of Philadelphia. Afternoon speaker will be Dr. Jeanne C. Bateman, clinical instructor in medicine, George Washington University School of Medicine, Washington, D. C., and Dr. Manuel E. Lichtenstein, of Chicago. Dr. Julius Michaelson, president of the American Academy of General Practice, Foley, Alabama will be the luncheon speaker.

Baldwin Doctor Appointed To Governor's Committee

Dr. John E. Foster of Foley has been appointed a member at large on Governor George Wallace's Industrial Advisory Committee.

Dr. Foster is active in civic and community development and served as president of the South Baldwin Chamber of Commerce this year.

He is a past president of the Alabama Academy of General Practice.

Gastroenterologists Meet March 7 in New Orleans

The Southern Regional Meeting of the American College of Gastroenterology will be held in New Orleans, La., on Sunday, March 7, 1965 at the Roosevelt Hotel and will convene at 2:00 P. M.

Gastroenterology Symposium March 31-April 2 In Augusta

A continuing medical education symposium on Gastroenterology will be presented March 31-April 2, 1965 at the Medical College of Georgia, Augusta, Georgia. The guest faculty includes three nationally recognized teachers and clinicians who will join with members of the Medical College of Georgia faculty in discussing the medical and surgical approach to problems in gastroenterology.

Sports-minded physicians are reminded that this symposium immediately precedes the Masters Golf Tournament which will be played at the Augusta National Golf Club, April 4-11.

For a symposium brochure listing the subjects to be discussed and participating faculty, write to the Department of Continuing Education, Medical College of Georgia, Augusta, Georgia.

Parke, Davis Distributing New Measles Vaccine

Parke, Davis & Company has announced plans for the nationwide distribution of measles vaccine.

The vaccine was developed by Philips Roxane, Inc., of St. Joseph, Mo., and Columbus, Ohio, and recently approved by the Federal Government. The vaccine is the live, attenuated type and is indicated for preventive immunization against naturally occurring nine-day measles.

The vaccine, developed after more than six years of laboratory work, has produced no serious side effects during the clinical field trials involving approximately 130,000 children, and these trials proved the effectiveness of the vaccine, with predicted life-long immunity, in 94 to 97 per cent of those vaccinated.

Environmental Health Ills Subject Of Second Congress

AMA's Second Congress on Environmental Health Problems is to be held April 26-27, 1965 at the Drake Hotel in Chicago.

The Congress, based on the theme "Population, Environment and Health," will have as its purpose an endeavor to broaden understanding of the interaction between man and his environment in the belief that this will help to improve medical practice and build more healthful environments. Panels will be devoted to evaluating the effect of changing environments on living cells, viruses, air, water, food and physical and mental health; reviews of changing disease patterns, such as the social, and biological factors which underlie current trends in incidence of various diseases; consideration of ways of prevention of disease through medical and public health practices and environmental engineering and legislation; and the final panel will analyze the potentials of urban planning in terms of building to improve health and well being through specific planning and the role that the medical profession will play in these health objectives.

For further information concerning this congress contact: Department of Environmental Health, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Yolles Appointed Director Of Mental Health Institute

The appointment of Stanley F. Yolles, M. D., as Director of the National Institute of Mental Health has been announced by Surgeon General Luther L. Terry.

Dr. Yolles succeeds Dr. Robert H. Felix, who retired October 1, 1964 to become Dean of the College of Medicine at St. Louis University.

NUMBER OF BLOOD BANKS PASSES 1,000

The American Association of Blood Banks has passed the 1,000 mark in its program of inspecting and accrediting blood banks and hospitals to assure that their techniques of drawing, storing and administering blood meet highest medical requirements.

Dr. Oscar B. Hunter, Jr., of Washington, chairman of the AABB inspection and accreditation committee, observes that "Accreditation means that any patient receiving a transfusion of blood from an AABB-accredited bank can be confident that the bank has voluntarily met the highest scientific standards."

To date, 779 community and hospital blood banks have been accredited. Inspections of these facilities are repeated periodically so that the total number of inspections now exceeds 1,000.

Alabama blood banks are located at:

Birmingham Baptist Hospitals, Birmingham; Holy Name of Jesus Hospital, Gadsden; Homer D. Cobb Memorial Hospital, Phenix City; Mobile Infirmary, Mobile; Peoples Hospital, Jasper; St. Margaret's Hospital Laboratory, Montgomery; St. Vincent Hospital and University Hospital and Hillman Clinic, Birmingham.

San Francisco To Host Annual Ob-Gyn Meeting

The American College of Obstetricians and Gynecologists announce their Thirteenth Annual Clinical Meeting, April 4-8, 1965, to be held in San Francisco at the Civic Auditorium.

Scientific papers, round tables, panel discussions, luncheon conferences, forums on current investigations, motion pictures, closed-circuit color television programs and scientific and commercial exhibits will comprise the program.

New Radiation Council Opens Headquarters In Washington

Establishment of national headquarters for the newly-created National Council on Radiation Protection and Measurements (NCRP) is announced by Dr. Lauriston S. Taylor, president of the council. W. Roger Ney is Executive Director.

The Council, successor to the National Committee on Radiation Protection and Measurements, has been chartered by Congress as a non-profit corporation to collect, analyze, develop, and disseminate scientific information and recommendations about radiation measurement and protection against radiation.

Pan-American Meeting Of Pediatricians Planned

The American Academy of Pediatrics will hold its Spring session April 26-29 at the Americana Hotel, Bal Harbour, Florida.

The Academy is the Pan-American association of pediatricians. It has some 8,500 members in the United States, Canada, and Latin America.

Course On Rehabilitation Of Handicapped Scheduled

The Fourth Annual Course in Principles of Rehabilitation of the Physically Handicapped will be given under the sponsorship of the University of Miami School of Medicine and the Rehabilitation Center for Crippled Children and Adults, March 22nd-26th, 1965, in Miami.

Inquiries should be addressed to Dr. Pedro Arroyo, Jr., Rehabilitation Center for Crippled Children and Adults, 1475 N. W. 14th Avenue, Miami, Florida.

Georgia Arthritis Group Slates Seminar February 13-14

A seminar on Arthritis will be held at the Academy of Medicine in Atlanta February 13-14, 1965, under sponsorship of the Georgia Chapter of the Arthritis Foundation. The announcement was made by Dr. Vernon E. Powell, President of the Georgia Chapter.

Faculty will include Doctors Howard F. Polley, Mayo Clinic; Lee Ramsay Straub, Hospital for Special Surgery; Charley J. Smyth, Medical Center, University of Colorado; Mack L. Clayton, Denver Orthopedic Clinic; Robert L. Bennett, Warm Springs Foundation; William S. Clark, President, and Ronald Lamont-Havers, Medical Director, The Arthritis Foundation.

Mr. Jerry Gould Appointed AMA Representative To State

Mr. Jerry Gould of Charleston, West Virginia, Assistant to the Executive Secretary of West Virginia State Medical Association, has joined the staff of the Field Service Division of the American Medical Association. With headquarters in Chicago, Mr. Gould will serve as AMA representative for the states of Alabama, Tennessee, Mississippi, and Florida. Before joining the West Virginia State Medical Association, Mr. Gould was employed for sixteen years as a newspaperman. He is married to a registered nurse, and they have eight children.

Doctors:

Have you mailed in the questionnaire which appeared in the January issue of your MASA Journal? This is urgent if your Journal is to serve you better.

County Society Officers

Baldwin County

Dr. Richard A. Rowe — President
Foley
Dr. John E. Foster — Vice President
Foley
Dr. Ferdinand H. Dietze — Secretary-Treasurer
Fairhope

Chambers County

Dr. Joseph R. Gladden — President
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OBITUARIES

DR. CARL TURNER MARTIN

Dr. Carl Turner Martin, age 64, died December 30 after suffering a heart attack in his office. He had practiced medicine at Headland, Alabama for more than twenty-five years. Survivors include the widow, Mrs. Florrie Martin and a son, Carl T. Martin, Jr., of Atlanta.

DR. GORDON C. USSERY, SR.

Alabama lost one of its most beloved physicians on December 9 when Dr. Gordon C. Ussery, Sr., of Roanoke died in a Birmingham hospital after a long illness. He was 69 years of age and had spent his entire lifetime in Roanoke—42 years in the practice of medicine. His service included chief of staff of the Randolph County Hospital and president of the Randolph County Medical Society. Surviving, in addition to his widow and two daughters, is one son, Dr. Gordon C. Ussery, Jr., of Birmingham.

DR. E. G. SANDLIN

Dr. E. G. Sandlin, who was 81 years of age, died in Tuscaloosa on January 2, 1965 after a long illness. He had practiced medicine in Houston and Cullman Counties for fifty years, having come to Alabama from his native town of Cuthbert, Georgia. Survivors, besides his wife, Mrs. Florence Burkett Sandlin, include two sons, Rupert Sandlin of Pansey and McDewain Sandlin of Rome, Georgia; and three daughters, Mrs. Mary Ellen Kupinse of West Haven, Conn., Mrs. Katheryn Bond of Denver, Colo., and Miss Alice Sandlin who resides in Tuscaloosa.

DR. EDWARD L. TAYLOR

Dr. Edward L. Taylor, a resident of Guntersville, and a well known radiologist in that area, died on November 25, 1964. Dr. Taylor had resided in Guntersville since 1962 and was chairman of the Finance Commission of the Guntersville First Methodist Church, a Mason, a member of the Guntersville Chamber of Commerce, and a member of the Marshall County Medical Society. Dr. Taylor is survived by his wife, Mrs. Mary Wood Taylor, and three daughters, Mary Ann, Leah Elise and Tenley Sue, all of Guntersville.

DR. GEORGE W. NEWBURN, SR.

Dr. George W. Newburn, Sr., who served as personal physician to thousands of Mobilians for over 56 years, died November 21, 1964. Dr. Newburn was a member of the 50-Year Club of the State Medical Association, and was a lifetime member of the Trinity Episcopal Church in Mobile. He is survived by three sons who are in active practice in the Mobile area: Dr. Francis Newburn and Dr. Heubert Newburn are dentists there, while Dr. George W. Newburn, Jr., is a general practitioner. Other survivors include his wife, Mrs. George W. Newburn, Sr., and a daughter, Mrs. O. A. Moore of Downs, Alabama.

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10 Regional Institutes Set On Health Care Of Aging

The Joint Council to Improve Health Care of the Aging will hold 10 Regional Institutes on Nursing Home Care to be held during 1965.

The new series is designed to expand on the format developed during six institutes held in 1964 which stressed the importance of the nursing home as a medical facility and the needs of the long-term patient.

Atlanta has been selected as the site of the first 1965 institute, February 15-17. Other conferences will be in Minneapolis; Seattle; Columbus, Ohio; Toronto, Canada; Denver; Boston; Philadelphia; Dallas and Los Angeles.

Alabama Department of Public Health

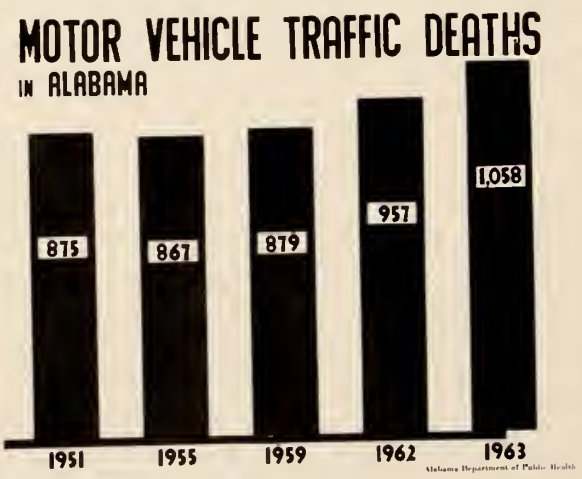
THE EPIDEMIC

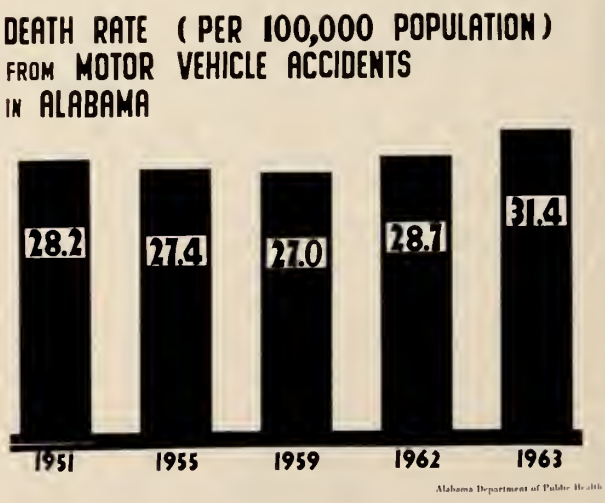
ALEC C. NATIONS, Coordinator

Accident Prevention Program
Alabama Department of Public Health

In recent months there has been increased interest shown in the motor vehicle accident problem in Alabama. The Governor's Traffic Safety Committee has been largely responsible for stimulating much of this interest. The Alabama Department of Public Health is represented on this committee by the State Health Officer. Through the efforts of this committee the need for developing methods to reduce one of Alabama's greatest health problems is now recognized. Since our main purpose in public health is to save lives, it was felt we could make a significant contribution to the committee by further defining the motor vehcile fatality problem in this state. Our accident prevention program, dealing primarily with accidents occurring in and around the home, was initiated a year and a half ago. Using the epidemiological approach in studying home accidents and home accidental deaths in Alabama gave us a good base to apply to the traffic fatality problem. A study of motor vehicle fatalities in relation to other accidental deaths has recently been completed by the Alabama Department of Public Health. This furnished the committee statistical data which had not been available to them.

There are numerous factors involved in attempting to define the causes of motor vehicle accidents. This initial study was made to determine the relationship of the motor vehicle mortality problem to the changing transportation habits of Alabamians. For





example, the death rate per 100 million miles traveled has increased from 6.0 in 1959 to 6.2 in 1963. There has been a 20.9 per cent increase in fatalities from 1951 to 1963. The death rate per 100,000 vehicles has increased from 73.3 in 1959 to 74.1 in 1963. The charts on page 246 indicate the total number of deaths and the increase in the motor vehicle mortality rate per 100,000 population.

This study indicates that the motor vehicle mortality rate is increasing each year not only by total number of deaths but also in relation to the increased use of automobile transportation. Comparisons made with other states who have a lower motor vehicle fatality rate suggest a number of concrete events which must occur. The immediate goal should be for all of Alabama's citizens to be made aware of this increasing health problem. Knowledge of the need should encourage the full cooperation of each adult in actively supporting required motor vehicle inspections, driver education training, and the installation and use of restraining devices by all persons riding in motor vehicles.

Since all members of the Medical Association make up the State Board of Health, it is hoped that each physician will actively support good legislation for vehicle inspection, driver training, and the installation of seat belts in all vehicles.

Pioneer Of Hill-Burton Program Leaves U. S. Post

Surgeon General Luther L. Terry of the Public Health Service has announced the retirement of John R. McGibony, M. D., Chief of Intramural Research, Division of Hospital and Medical Facilities of the U. S. Department of Health, Education, and Welfare, Washington, D. C.

Dr. McGibony, who helped lay the groundwork for the Hill-Burton Hospital Construction program, began his varied career in 1927 after receiving his M. D. from the Medical College of Georgia.

BUREAU OF PREVENTABLE DISEASES

W. H. Y. Smith, M. D., Director

CURRENT MORBIDITY STATISTICS

1964

	Nov.	Dec.	*E. E. Dec.
Tuberculosis	76	52	119
Syphilis	147	147	100
Gonorrhea	220	268	254
Chancroid	0	1	5
Typhoid fever	1	1	2
Undulant fever	0	0	0
Amebic dysentery	5	0	2
Scarlet fever & strep. throat	258	297	80
Diphtheria	5	2	6
Whooping cough	27	40	10
Meningitis	1	10	8
Tularemia	0	0	0
Tetanus	1	0	1
Poliomyelitis	0	0	5
Encephalitis	0	0	0
Smallpox	0	0	0
Measles	41	91	60
Chickenpox	14	90	88
Mumps	16	17	40
Infectious hepatitis	30	25	26
Typhus fever	0	0	0
Malaria	0	0	0
Cancer	523	468	444
Pellagra	0	0	0
Rheumatic fever	14	6	13
Rheumatic heart	21	13	23
Influenza	55	39	119
Pneumonia	142	177	233
Rabies—Human cases	0	0	0
Pos. animal heads	3	3	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

BUREAU OF LABORATORIES

Thomas S. Hosty, Ph.D., Director

December 1964

Examinations for intestinal parasites	837
Typhoid cultures (blood, feces, urine and other)	285
Brucella cultures	2
Examinations for malaria	1
Examinations for gonococci	1,631
Serologic tests for syphilis (blood and spinal fluid)	19,183
Darkfield examinations	2
Agglutination tests	2
Examinations for diphtheria bacilli and Vincent's	51
Complement fixation tests	76
Examinations for Negri bodies (smears and animal inoculations)	203
Water Examinations	1,918
Milk and dairy products examinations	3,474
Examinations for tubercle bacilli	3,538
Miscellaneous examinations	5,124
	36,327

*Dothan Branch Laboratory report was not received in time to be included.

The Woman's Auxiliary



Dear Doctors:

My husband writes a weekly newspaper column so I don't see why he should be jealous if I write to you once a month. Anyway, I asked him to write a guest column for me. If you are planning on bringing your wife to the State Medical Convention and she is planning on attending the auxiliary meetings, you don't need to read any further.

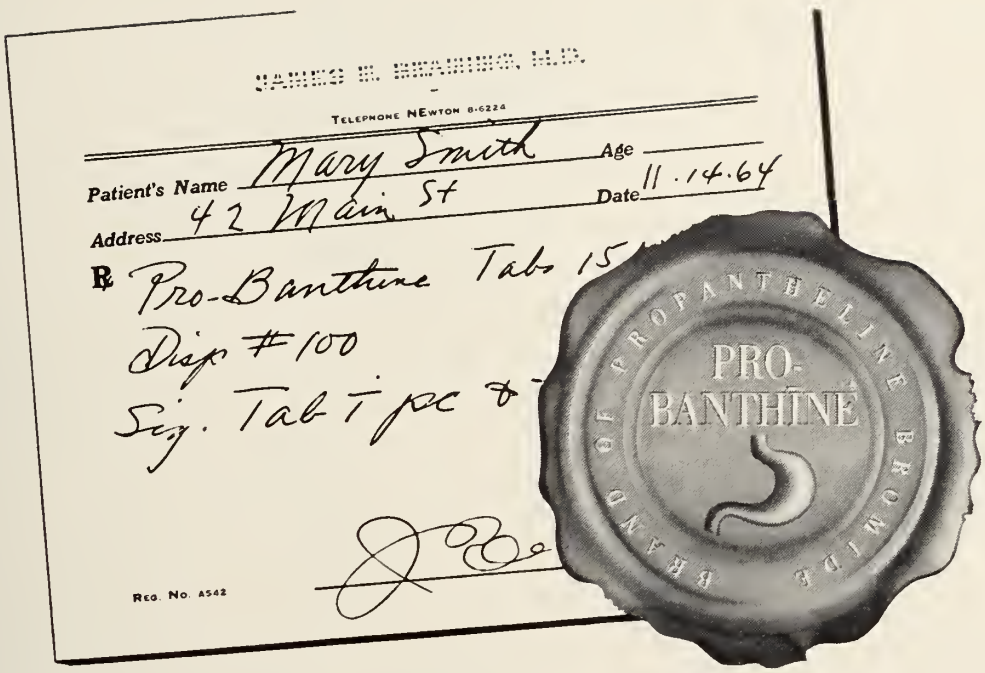
Sincerely,

Frances Clemmons

Lowell's Column:

Frances asked me if I could take a little pressure off her and tell why all the wives should come to Birmingham and attend the Auxiliary meetings. Reminds me of one of my OB's who said, "My husband poked a little fun at me and I took it seriously." All of you know I can't be too serious about anything, so I won't be. Don't think I've ever attended a State Medical Convention without taking Frances along. Back in the early days, right after World War II, I would look around and wonder why there were so many old doctors attending meetings and also wonder why there wasn't anybody around my age. So Frances and I would seriously attend the meetings, then entertain ourselves at night in various and sundry ways. Then a few years later, it seemed that everybody at every meeting was about my age so we were not quite as diligent at attending meetings, but we were more diligent in the social activities and there used to be a lot.

Now the wheel has continued turning and some of my contemporaries like Gordon Daves, John Chenault, E. B. Glenn and Winston Edwards stand around, try to look wise and wonder how some of these youngsters are old enough to be out of college, let alone medical school. Golly, they're graduating young these days. But, I'm back to the meetings and not dancing as much. Seems like there are a lot of reasons I need Frances along. Used to be that I urged her to attend the Auxiliary meetings so that she didn't have time to spend any money in the stores. Then later on I urged her to attend the meetings for the same reason. Now I don't have to urge her but I would and for the same reason. Besides that, it's handy to have her along. After all, somebody has to tie my shoes, take off my elastic stockings, wash my back, find my razor, hang up my clothes, tell me to go to bed, wake me up in the mornings, keep track of where I'm supposed to be at what time, remind me of peoples' names, tell me when I've had enough to eat and drink, wheel me back to the hotel, keep me from knocking on hotel doors as I walk down the corridor, operate the elevator for me, give me the latest dope on who's in and who's out in the Auxiliary, let me know which group plans to nominate the president-elect of the Association, etc., etc. Golly, fellows, you can't afford to attend the State Medical meeting without taking your wife along, you'd be lost. Besides that, we're going to meet at the Parliament House and you'd better have your wife along when you see those gals in the cocktail lounge. By the way, the Auxiliary meets at the Sheraton Motor Hotel which used to be the Colony and it's pretty OK too. You'd better plan to be there and for heavens sake, bring your wife because if your wife doesn't show up, my wife will be after me for not convincing you that your wife ought to be there.



Stamp of Approval on Virtually any Ulcer Regimen-

PRO-BANTHĪNE®

(propantheline bromide)

Historically, reduction of acid and motility in peptic ulcer has been approached through the use of antacids, dietary management and surgery.

Since 1953, however, Pro-Banthīne used alone or in addition to other measures has contributed importantly to achieving both of these goals. It has been shown repeatedly that adequate doses of Pro-Banthīne will significantly inhibit gastric acid secretion and reduce gastrointestinal motility.

So dependable have these actions been that now, for many, standard treatment of peptic ulcer and several allied conditions has become antacids *plus* Pro-Banthīne, dietary management *plus* Pro-Banthīne, surgery *plus* Pro-Banthīne, or some combination of the three.

Pro-Banthīne has become the most widely prescribed anticholinergic for patients with peptic ulcer, functional hypermotility, irritable colon, pylorospasm and biliary dyskinesia because patients respond favorably to its therapeutic actions.

Side Effects and Precautions—Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur. The drug is contraindicated in patients with glaucoma or severe cardiac disease.

Dosage—The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six tablets daily in divided doses. In severe conditions as many as four tablets may be given four times daily. Pro-Banthīne (brand of propantheline bromide) is supplied as tablets of 15 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

SEARLE

Chicago, Illinois 60680

Research in the Service of Medicine

too young to be so tired...



revive interest... restore activity promptly with

Alertonic®

Three tablespoonfuls (45 cc.) contain:		
Pipradrol hydrochloride		2 mg.
Vitamin B_1 (thiamine hydrochloride)	(10 MDR*)	10 mg.
Vitamin B_2 (riboflavin)	(4 MDR*)	5 mg.
Vitamin B_6 (pyridoxine hydrochloride)		1 mg.
Nicotinamide	(5 MDR*)	50 mg.
Choline†		100 mg.
Inositol†		100 mg.
Calcium glycerophosphate	(2% MDR for calcium and phosphorus)	100 mg.
Cobalt (as chloride)		1 mg.
Manganese (as sulfate)		1 mg.
Magnesium (as acetate)		1 mg.
Zinc (as acetate)		1 mg.
Molybdenum (as ammonium molybdate)		1 mg.
Alcohol 15%		

*Multiple of adult Minimum Daily Requirement supplied
†Requirement in human nutrition not yet established

the need for a tonic knows no age Anyone can feel tired and "old" too soon. In such functional fatigue, Alertonic helps to lift mood, revive interest, restore purposeful activity promptly. Yet it contains no MAO inhibitors, no hormones. Alertonic is the effective formulation of a cerebral stimulant (pipradrol hydrochloride), alcohol, vitamins, and minerals ...available on prescription *only*. For common functional complaints (mild mood depression, tiredness); geriatric or convalescent patients, Rx one *tablespoonful* Alertonic *t.i.d.*, thirty minutes before meals. Contraindicated in agitated pre-psychotic patients, paranoia, or other patients in whom hyperexcitability, anxiety, chorea, or obsessive-compulsive states are present. Mild central stimulant side effects may occasionally occur.

Brochure with full product information available on request.

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"Your Story in Pictures Leaves Nothing Untold"

Your patients will say "The Pain Is Gone" when you prescribe

'EMPIRIN'® COMPOUND with CODEINE gr. 1/2



'EMPIRIN' COMPOUND with CODEINE gr.1/2 (No. 3)
KEEPS THE PROMISE OF PAIN RELIEF

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

in maintenance therapy... a working analgesic for the active arthritic

ARTHRALGEN®

Each tablet contains:

Salicylamide	250 mg.
Acetaminophen	250 mg.
Ascorbic acid (Vitamin C)	25 mg.

a working analgesic for the active arthritic

—rapidly relieves early morning stiffness and arthritic pain. It promises a quicker response in most patients because its analgesic ingredients need no metabolic conversion before they act. As a combination of two prominent analgesic drugs, Arthralgen can often establish smoother, more complete pain relief because it synergistically produces more efficient analgesia on lower dosage levels of each.

two proven pain relievers

Arthralgen combines two better-tolerated, time-tested analgesics, acetaminophen and salicylamide, into a pharmacologically sound and therapeutically effective formulation. As Arthralgen, it penetrates tissues promptly and relieves pain rapidly with less likelihood of gastric irritation than aspirin.

sodium-free

Arthralgen contains no sodium. Therefore, it is often a safer and more suitable analgesic for use in the long-term treatments of arthritic patients who have other conditions which require sodium restriction.[1]

ARTHRALGEN®-PR (Arthralgen with prednisone)

Each tablet contains:

Salicylamide	250 mg.
Acetaminophen	250 mg.
Ascorbic acid (Vitamin C)	25 mg.
Prednisone	1 mg.

To help provide dosage flexibility in patients who require steroids, the basic Arthralgen formula is also available combined with prednisone as Arthralgen-PR. Prednisone is favored as the more advantageous steroid for use in Arthralgen-PR because it shows less tendency toward sodium retention, potassium excretion, and steroid-induced hypertension than that which often accompanies the use of cortisone and ACTH.[2]

A. H. ROBINS COMPANY, INCORPORATED/RICHMOND, VIRGINIA

BRIEF SUMMARY

Arthralgen and Arthralgen-PR are indicated in the management of rheumatoid arthritis, acute gouty arthritis, rheumatoid spondylitis, osteoarthritis, bursitis, fibrositis, and neuritis. Arthralgen may be used for analgesia in colds, flu, and various myalgias.

DOSAGE: One or two tablets four times a day. After remission of symptoms dosage should be reduced to the minimum maintenance level.

SIDE EFFECTS: Nausea, GI upset, or mild salicylism may rarely occur. Symptoms of hypercorticoidism dictate reduction of dosage of Arthralgen-PR.

PRECAUTION: Reduction in dosage of Arthralgen-PR given over a long period should be gradual, never abrupt.

CONTRAINDICATIONS: Hypersensitivity to any ingredient.

As with any drug containing prednisone, Arthralgen-PR is contraindicated, or should be administered only with care, to patients with peptic ulcer, tuberculosis, nephritis, diabetes mellitus, acute psychoses, Cushing's syndrome (or Cushing's disease), overwhelming spreading (systemic) infection, or predisposition to thrombophlebitis.

Arthralgen-PR is generally contraindicated in patients with uremia and viral infections, including poliomyelitis, vaccinia, ocular herpes simplex, and fungus infections of the eye. It is also contraindicated in patients with chicken pox or susceptible persons exposed to it.

SUPPLY: Arthralgen (white, scored) and Arthralgen-PR (yellow, scored) tablets are available in bottles of 100 and 500.

REF: 1. Boreus & Sandberg, ACTA. PHYSIOL. SCAND., 28:266, 1953. 2. Cohen, et al.: J.A.M.A., 165:225, 1957.



ɔir better, Mrs. Smith?



My, yes! I'm not tired out anymore.



Headaches still bother you?



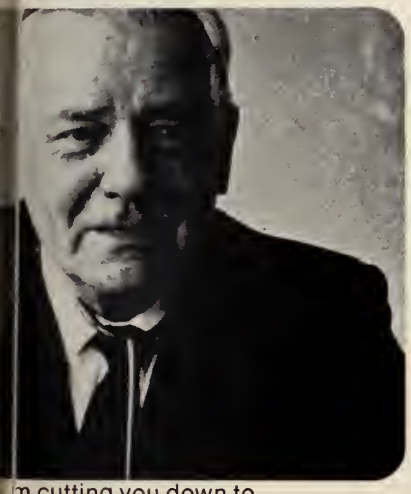
at ll. I feel wonderful!



Mmm. Normal. Must be taking your Regroton.



One a day at breakfast. Sure is easy on me.



. m cutting you down to aablet daily.



Thanks for everything, Doctor. See you on the 3rd.



...excellent response to Regroton, from 196/120 to 145/90.

ction: Each tablet contains chlorthalidone, g.and reserpine, 0.25 mg.

a dications: History of mental depression, ɔsitivity, and most cases of severe renal p ic diseases.

w. Discontinue 2 weeks before general thsia, 1 week before electroshock therapy, f epression or peptic ulcer occurs.

a *ons:* Reduce dosage of concomitant anti-rhsive agents by one-half. Discontinue if BUN rises or liver dysfunction is aggravated. tryte imbalance and potassium depletion ccur; take particular care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.

Side Effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.

For full details, see the complete prescribing information.

Availability: Bottles of 100 and 1000 tablets.

Average Dosage: One tablet daily with breakfast.

*Chupkovich, V.; Finnerty, F. A., Jr., and Kakaviatos, N.: The value of chlorthalidone plus reserpine in moderately severe and severe hypertension: A two year study. Presented at the 7th Inter-American Congress of Cardiology, Montreal, June 14–19, 1964.

Geigy Pharmaceuticals
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Superior to other antihypertensives in 76 of 80 patients during a 2-year study*

Geigy

Stelazine® brand of trifluoperazine
will calm your anxious working patient—with little or no drowsiness

When anxiety interferes with work, your patient needs a drug that will calm without causing undue drowsiness. With Stelazine (trifluoperazine, SK&F), you can promptly control the anxiety without producing the sedation seen with certain other agents. Anxious patients can remain active during therapy.



Stoll[1] used the drug in 50 patients with anxiety, and noted: "There was no drowsiness in this group of patients and, because of their alertness and less impaired concentration, they were able to continue with and, in some cases, return to their daily work."

Stelazine (trifluoperazine, SK&F) produces a fast therapeutic response—often within 24 to 48 hours. The convenient b.i.d. regimen frees patients from the need for a midday dose.

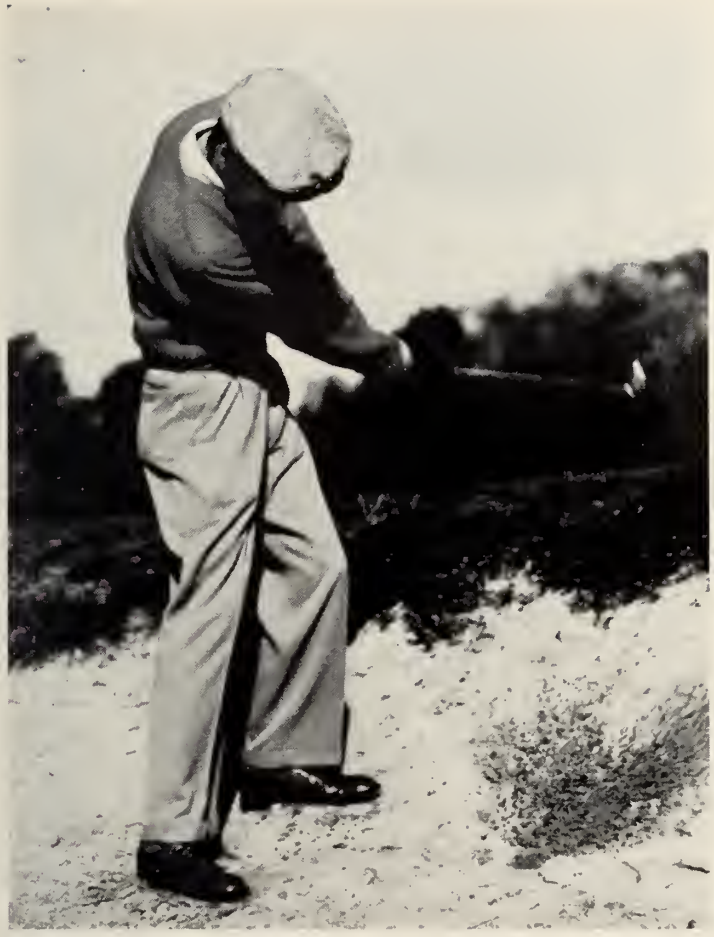
Principal side effects, usually dose-related, may include mild skin reaction, dry mouth, insomnia, fatigue, drowsiness, dizziness, amenorrhea and neuromuscular (extrapyramidal) reactions. Muscular weakness, anorexia, rash, lactation and blurred vision may also be observed. Blood dyscrasias and jaundice have been rare. Use with caution in patients with impaired cardiovascular systems. *Contraindicated* in comatose or greatly depressed states due to CNS depressants and in cases of existing blood dyscrasias, bone marrow depression and pre-existing liver damage.

Before prescribing, see SK&F Product Prescribing Information.

Photograph professionally posed.

1. Stoll, L. J.: The Use of Trifluoperazine ['Stelazine'] in General Practice, M. Press 243:578 (June 29) 1960.

SK&F **Smith Kline & French Laboratories, Philadelphia**



Your patient doesn't have to be in the Masters to get sprains and strains

Regardless of the etiology of muscle sprain or strain, 'SOMA' COMPOUND helps relieve pain and relax muscle. Patient comfort can be increased and recovery time shortened.

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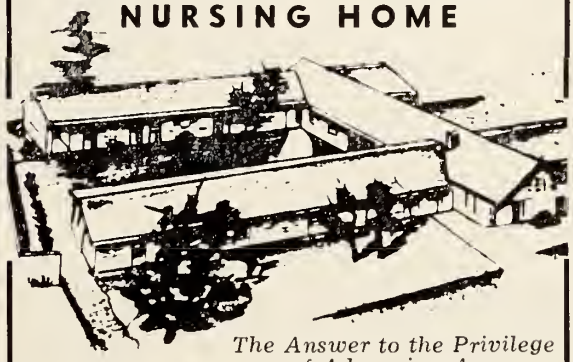
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At the age of 19 he became a country school teacher, a position he held for six years. In 1855—at the age of 24—he married Miss Sarah Jane Collins, daughter of a well-to-do farmer and entered the Botanic Medical College at Memphis, Tennessee.

He was graduated in 1857 as a Doctor of Medicine, valedictorian of his class. However, as a student he had become conscious that the botanic system of instruction was untenable in certain areas and, after two years of practice in North Mississippi, he enrolled in the medical department of University of Nashville. With 153 others, he received in 1861 his second doctorate in Medicine, again ranking first in his class.

Dr. Cochran spent the entire Civil War time tending to troops in Mississippi and Alabama. With cessation of hostilities, he hung out his shingle in Mobile. When the Medical College of Alabama was reopened in Mobile after being closed for seven years, he was elected Professor of Chemistry.

With a small group of doctors, he met in Selma in 1868 to reorganize the Alabama State Medical Association (also a casualty of the war) and became its recording secretary. He later was to lead the fight to transform the Association from a loosely-bound group into a compactly-organized body which would be "thoroughly disciplined but a self-perpetuating medical legislature."



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*Lennox, W. G.: Epilepsy and Related Disorders, Boston, Little, Brown and Company, 1960, vol. 2, p. 865.

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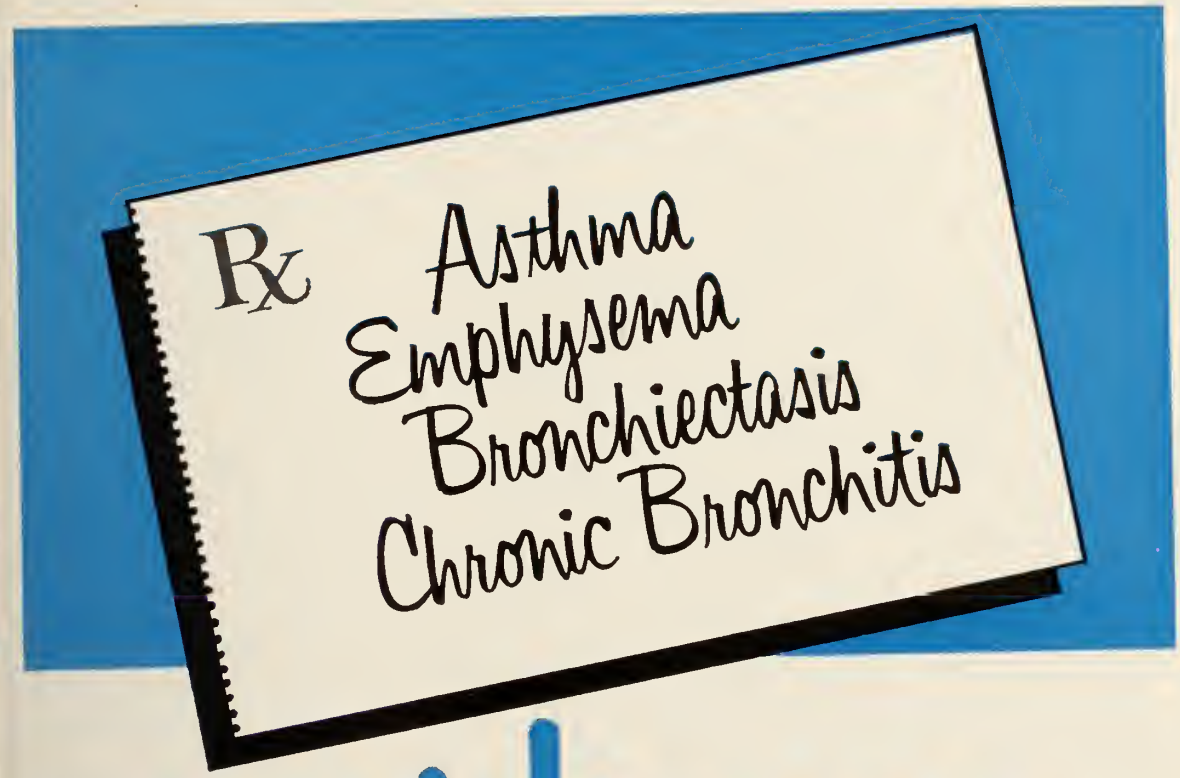
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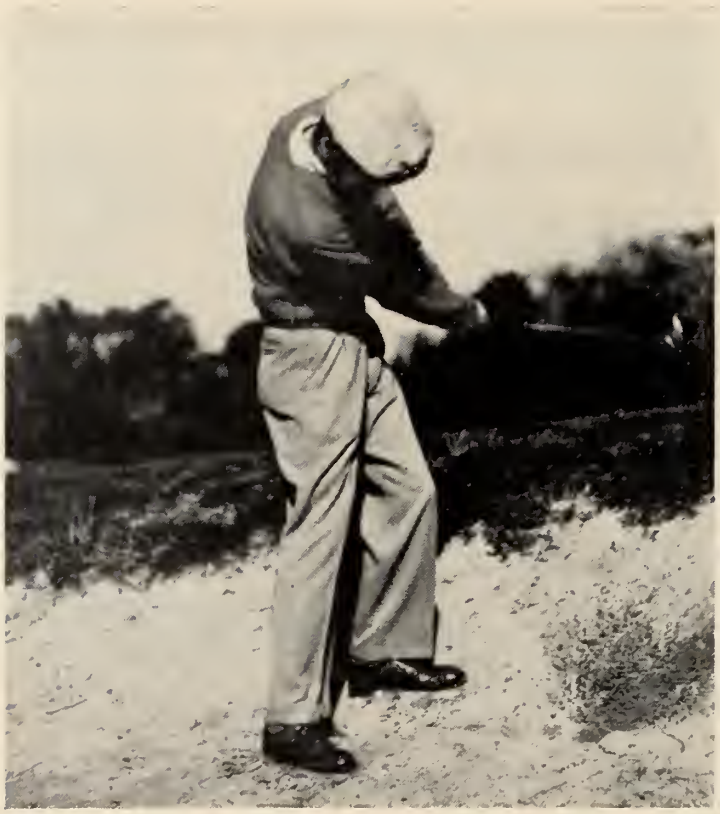
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(Warning: Codeine may be habit-forming.) **Indications:** 'Soma' Compound and 'Soma' Compound with Codeine are useful for relief of pain and stiffness in traumatic, rheumatic and other conditions affecting muscles and joints. **Contraindications:** Allergic or idiosyncratic reactions to carisoprodol, phenacetin, or codeine phosphate. **Precautions:** *Phenacetin*—With long-term use, give cautiously to patients with anemia and cardiac, pulmonary, renal or hepatic disease. May damage the kidneys when used in large amounts or for long periods. *Caffeine*—Not recommended for persons extremely sensitive to its CNS stimulating action. *Codeine phosphate*—Use with caution in addiction-prone individuals. *Carisoprodol*—Carisoprodol, like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g. meprobamate. **Side effects:** Drowsiness, lightheadedness, dizziness, and gastric complaints have been reported infrequently for either or both of these preparations. *Phenacetin*—Side effects are extremely rare with short-term use of recommended doses. Prolonged ingestion of overdoses may produce dyspnea, cyanosis, hemolytic anemia, skin rash, anorexia, subnormal temperature, insomnia, headache, mental disturbances, and tolerance. *Caffeine*—Side effects are almost always the result of overdosage. Average doses may rarely cause nausea, nervousness, insomnia, and diuresis. Excessive dosage may produce, in addition, restlessness, nervousness, tolerance, tinnitus, tremors, scintillating scotomata, tachycardia, and cardiac arrhythmias. *Codeine phosphate*—Possible side effects are nausea, vomiting, constipation, and miosis. *Carisoprodol*—The only side effect reported with any frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. Other rarely observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, and gastrointestinal symptoms. One instance each of pancytopenia and leukopenia, occurring when carisoprodol was administered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodol and subsequent cross-reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reaction, carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression. **Dosage:** Usual adult dosage of 'Soma' Compound or 'Soma' Compound with Codeine is one or two tablets three times daily and at bedtime. **Supplied:** 'Soma' Compound, orange tablets, each containing carisoprodol 200 mg., phenacetin 160 mg., and caffeine 32 mg. 'Soma' Compound with Codeine, white capsule-shaped tablets, each containing carisoprodol 200 mg., phenacetin 160 mg., caffeine 32 mg., and codeine phosphate 16 mg. Narcotic order form required. *Before prescribing, consult package circular.*

WALLACE LABORATORIES
Cranbury, N. J.

CSO-5114



Of 1,088 patients with confirmed skin and soft-tissue infections... 1,036 or 95.2% were treated successfully with Signemycin®

Note:
Morador et al.* obtained *excellent results in the treatment of 185 out of 191 soft-tissue infections*, all due to staphylococci. They state: "In the most serious infections occurring in patients with impaired resistance (mainly diabetics) we have had very good results in the control of the infectious condition." In these studies, incision and drainage were employed where indicated.

*Morador, J. L. et al.: Antibiot. Ann. 1959-1960:716.

Condition	No. of Patients	No. Responded To Signemycin
Abscesses, various	35	34
Abscess, gluteal or perianal	54	52
Burns, infected	331	307
Carbuncles and furuncles	125	122
Cellulitis	104	102
Lacerations and wounds, infected	142	128
Ulcers, infected	107	106
Various superficial infections	190	185
Totals	1,088	1,036 (95.2%)

consistently effective...often when others fail

Signemycin®

tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Also available as Syrup, Pediatric Drops, and half-strength Capsules

Brief Summary and Bibliography follow.

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SIGNEMYCIN®

Side Effects: Glossitis and allergic reactions, as well as severe anaphylactoid reactions, have been reported as rare side effects. Should significant reaction or idiosyncrasy occur, discontinue medication and institute countermeasures. Use of tetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. Reduce usual oral dosage and consider serum level determinations in patients with impaired renal function to prevent possible liver toxicity due to excessive accumulation of antibiotic in the serum.

Precautions: Overgrowth of nonsusceptible organisms may occur. In such cases, discontinue medication and institute appropriate specific therapy as indicated by susceptibility testing. Aluminum hydroxide gel given with antibiotics has been shown to decrease their absorption and is contraindicated. The coloring agents used in Signemycin Syrup and Pediatric Drops may produce red discoloration of stools.

Triacetyloleandomycin, a constituent of Signemycin, administered to adults in daily oral doses of 1.0 Gm. (3 Gm. Signemycin) for periods of more than ten days may produce hepatic dysfunction and jaundice. In the rare patient who requires this high dosage level of Signemycin initially, liver function should be carefully followed and dosage should be reduced, as promptly as possible, to the usual recommended range of 1.0 to 2.0 Gm. per day. Therefore, Signemycin is recommended primarily for the treatment of acute or severe infections, with treatment restricted to a ten-day period. If clinical judgment dictates continuation of therapy beyond ten days, serial monitoring of the liver profile should be carried out, including BSP, transaminase, and cephalin flocculation tests. Changes observed in liver function were reversible following discontinuation of the drug.

Formulas: Capsules: 250 mg. Signemycin (167 mg. tetracycline HCl and 83 mg. oleandomycin as triacetyloleandomycin).

Capsules: 125 mg. Signemycin (83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin).

Syrup: 125 mg. Signemycin (tetracycline equivalent to 83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin) per 5 cc.

Pediatric Drops: 100 mg. Signemycin (tetracycline equivalent to 67 mg. tetracycline HCl and 33 mg. oleandomycin as triacetyloleandomycin) per cc.

More detailed professional information available on request.

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Of 5,057 patients with confirmed infections of all body systems... 4,731 or 93.5% were treated successfully with Signemycin®

Note:

The high rate of response to Signemycin in these cases is noteworthy because the totals include many patients with difficult-to-treat infections, many whose infections had proved resistant to other agents, and many who had been treatment failures on other therapy.[1-87] In addition the following criteria were used for the cases cited: (1) only published results were used (2) results were confirmed by clinical and/or laboratory findings (3) patients were cured, not "improved" (4) dosage conformed with current recommendations in the United States (5) no other anti-infective agents were used concomitantly (6) no instance of prophylactic use was included in these tabulations.

Condition	No. of Patients	No. Responded To Signemycin
Ear, nose and throat infections	507	465
Respiratory infections	1,028	954
Gastrointestinal infections	425	387
Genitourinary infections	748	684
Skin and soft-tissue infections	1,088	1,036
Bone and joint infections	71	64
Deep-seated or generalized infections	257	251
Obstetrical & gynecological infections	341	320
Miscellaneous conditions	592	570
Totals	5,057	4,731 (93.5%)

consistently effective...often when others fail

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tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

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President's Page

As this year for the Association draws to a close, the great battle of Medicare vs. Eldercare continues as an all-consuming problem. A great deal was learned in the first episode in this fight just before the November election, particularly in regard to communication with the membership. In a problem such as this, to notify 2,300 members of our Association and ask them to act quickly in contacting their Congressmen by telegram takes team-work. The central office staff printed the letters, stuffed the envelopes, stamped and got those letters in the mail Friday in time for the Congressmen to receive a telegram on Tuesday.

The AMA has recognized the importance of fast communication on a mass scale. The teletype equipment purchased by AMA has been installed in our central office. This has been done in 37 state association offices. We will now be able to get firsthand and rapidly-transmitted information on legislative and other matters.

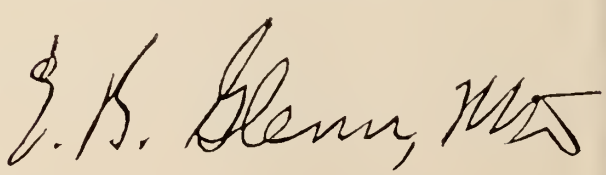
The new medicare bill was presented in the Senate and House as one of the first things on the agenda. The AMA program to combat this legislation in the 89th Congress has begun with the third phase of its campaign, the educational one. AMA offered the State Association $2.50 per member to be matched by the Association. This money is to be used for any program that the state association feels would be effective in opposing the menace of the Administration's Health Care Bill. This expenditure has been made upon approval of the Board of Trustees and Board of Censors. A program of television and radio advertising, together with newspaper advertising, paid for from this fund, is in effect. Contact with the membership to repeat "Operation Hometown" is going on. Every effort is being made to instruct the public and the membership.

It was first thought that little needed to be done in Alabama since seven out of eight Congressmen were conservative and consequently would represent our viewpoint. This was found not to be true—the two Senators will do what the Administration wants done. Several of our Representatives have taken the viewpoint that "the doctors must compromise." This expression was heard after Mr. Wilbur Mills indicated he would support separate funding for medicare under Social Security. Dr. Edward Annis made the statement that President Johnson "has his troubles" and everything would not be as "smooth sailing" for him as it appeared to be. The local press indicates we are licked because we are "too late" with a positive attitude.

The AMA plan is the right one. It helps the individual take care of himself, and it does far more for everyone than the limited King-Anderson program. The younger generation will pay for the latter. Assistant HEW Secretary, Wilbur J. Cohen, who has masterminded this legislation, is known to want only "Medical care for the aged under Social Security," and that is all he wants for "years to come." He is reputed to be "afraid" of coverage on a broader scale since he realizes he will not have control over such a program, nor will the President whom he advises.

Our Association authorized the expenses of a trip to Washington in February for Dr. E. W. Stevenson and Dr. R. M. Miller (both from Morgan County) with representatives of the Associated Industries of Alabama on the invitation of the latter. Appointments were made with the Alabama Congressional delegation and formal presentations were given opposing medicare. The two doctors volunteered their services. We should be grateful to them for taking the time and our gratitude should be shown to others who have worked on this program.

It helps to know that we have friends like the Associated Industries of Alabama, the Chamber of Commerce, the Farm Bureau, the Trucking Association, and other groups who support our viewpoint of free enterprise. We will support them when they need us.





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Side effects: Insomnia may occur if taken later than 6 hours before retiring. The usual peripheral actions of sympathomimetic amines (vasoconstriction and acceleration of the heart) are minimal and little noticed on low or moderate dosage.

Complete literature available on request from Professional Services Dept. PML

Contraindications and precautions: Should not be used in patients with myocardial degeneration, coronary disease, marked hypertension, hyperthyroidism, insomnia or a sensitivity to ephedrine-like drugs. Moderate hypertension in the obese is not necessarily a contraindication since it may be relieved as the overweight is reduced.

'Methedrine' brand Methamphetamine Hydrochloride: Tablets–5 mg., scored, in bottles of 100 and 1000.

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1. Clinical report on file, Medical Department, A. H. Robins Co., Inc.
2. Schiller, I. W. and Lowell, F. C.: New England J. Med. 261:478, 1959.

BRIEF SUMMARY: Indications: Dimetapp reduces nasal secretions, congestion, and postnasal drip for symptomatic relief of colds, U.R.I., sinusitis, and rhinitis. **Contraindications:** Antihistamine sensitivity. Not recommended for use during pregnancy. **Precautions:** Administer with caution in the presence of cardiac or peripheral vascular diseases and hypertension. Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. **Side Effects:** Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.

See product literature for complete prescribing information.

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ROBINUL® FORTE glycopyrrolate 2 mg. per tablet

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glycopyrrolate 2 mg. / phenobarbital 16.2 mg. / (warning: may be habit forming)

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Epstein[1] found glycopyrrolate's intensive antisecretory action to be exemplary. Breidenbach[2] was impressed by its pronounced antispasmodic effects. And Young and Sun[3] reported that a 2 mg. oral dose "did not affect gastric emptying or intestinal transit time. . . ." According to Slanger[4], the absence of annoying side effects is an important plus factor ". . . for it permits ready individualization of dosage for control of mild to severe symptoms." Posey[5] sums it up when he says, "In effect, with glycopyrrolate, one approaches an ideal agent for the management of peptic ulcer. With it a vagolytic effect may be obtained without interfering with gastric emptying—the medical equivalent to vagectomy plus an adequate drainage procedure."

We invite you to try Robinul (glycopyrrolate) in your practice. Discover firsthand how several subtle advantages add up to make it the superior anticholinergic agent.

BRIEF SUMMARY

INDICATIONS: In addition to its primary indications for duodenal and gastric ulcer, glycopyrrolate is indicated for other G-I conditions which may benefit from anticholinergic therapy. Robinul-PH Forte (glycopyrrolate 2 mg. with phenobarbital) is indicated when these situations are complicated by mild anxiety and tension.

CONTRAINDICATIONS: Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte, sensitivity to phenobarbital.

PRECAUTIONS: Administer with caution in the presence of incipient glaucoma.

SIDE EFFECTS: Dryness of the mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.

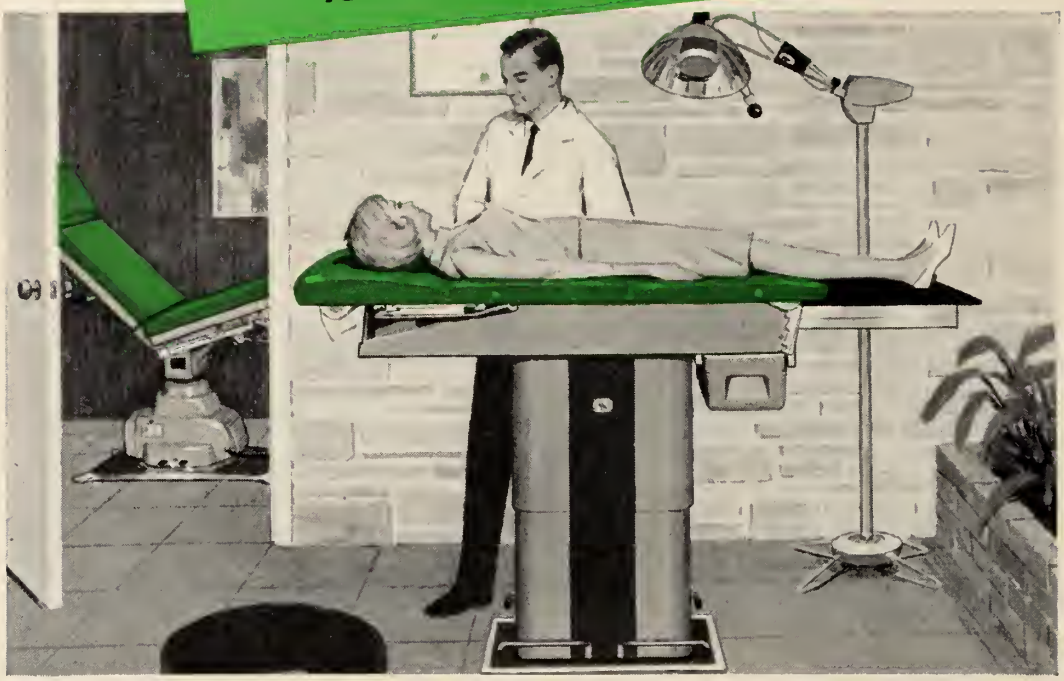
DOSAGE: Should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet three times a day: in the a.m., early p.m., and at bedtime. *See product literature for full prescribing information.*

Also available:
Robinul®(glycopyrrolate 1 mg. per tablet)
Robinul®-PH (glycopyrrolate 1 mg. per tablet)
phenobarbital 16.2 mg.
(warning: may be habit forming)

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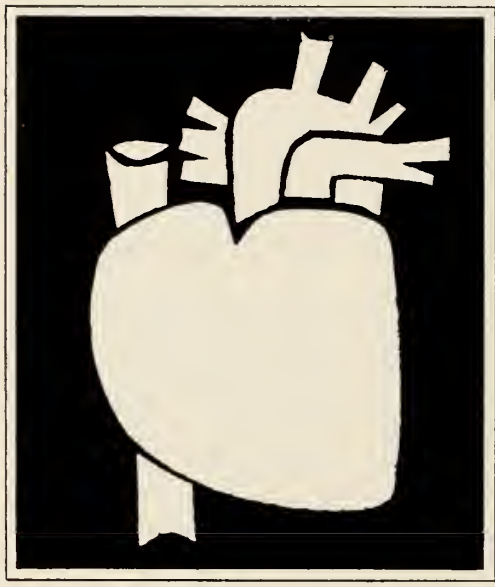
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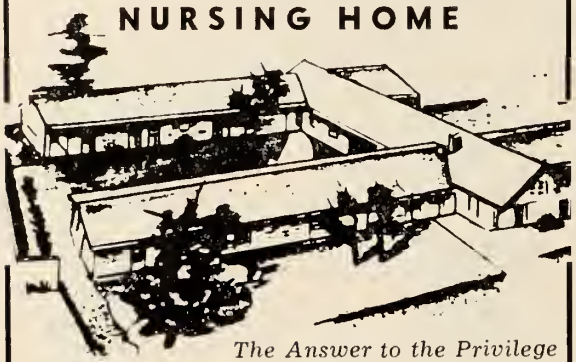
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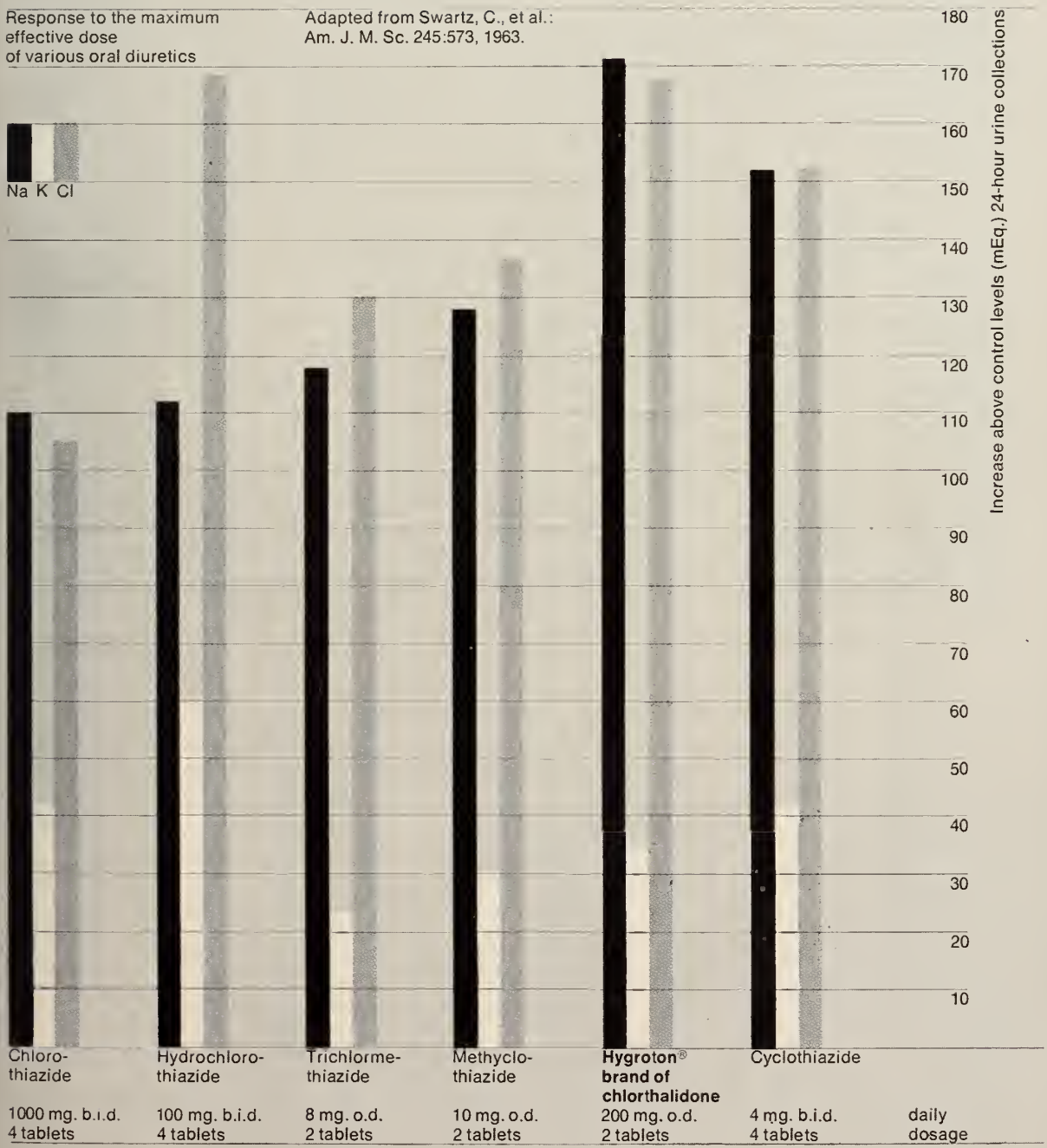
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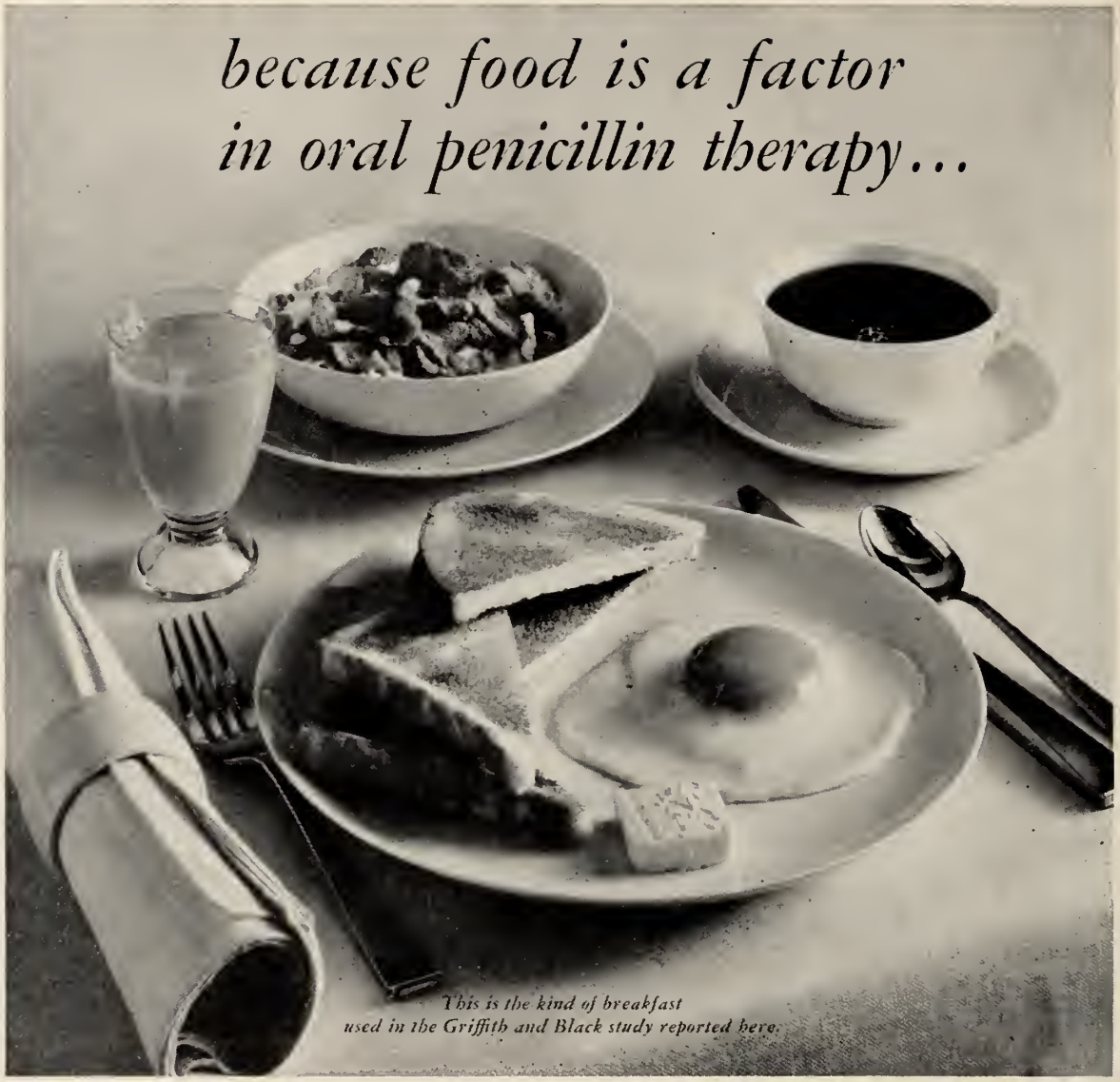
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1. Griffith, R.S., and Black, H.R.: Current Ther. Res., *6*: 253, 1964.

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Marshall-White Syndrome: Evidence of Vasomotor Conflict In A Particularly Severe Case

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Some years ago we reported a new syndrome[1] which consisted of (a) angiospastic macules of the palms of the hands. These spots were intermittent in nature and they were 0.4 degree cooler than the surrounding pinkish colored skin when measured with a thermocouple. (b) These patients experienced tachycardia, usually sinus arrhythmia, and (c) they gave histories of attacks with periodic insomnia.

These patients were almost continually nervous, and they also exhibited definite feelings of inferiority. They remarked that they would lie in bed at night and review the day's events, particularly if others had asked them to perform acts which they resented. They would then think of asserting their own feelings and rights the next time such occurrences would take place. These patients experienced the particular difficulty with asserting or enforcing their own opinions on others. However rather than cause any further controversy, they usually agreed to perform whatever tasks were asked of them. Such repeated psychic insults tended to increase their states of nervous tension and inferiority.

Our later observations, which concern the dermatologic aspects of this syndrome, demonstrated that some of these patients also exhibited such angiospastic patches on the dorsal areas of their lower extremities. However, the presence of these dermatologic changes were usually found, as reported previously, to be confined to the hands (palmar surfaces). Dangling the hands tends usually to increase their occurrence and intensity.

Since we first reported the above observations, we have discovered that this syndrome is not as rare as we had believed. Although

the presence of this clinical picture does not represent a serious physio-pathologic state in such patients, its main diagnostic value has been to give the clinician advance notice to at least consider the presence of a neurasthenic diathesis. We do not contend, however, that actual organic pathology cannot coexist in such patients with this syndrome. Rather, we merely desire to alert the clinician to the fact that he might be dealing with a highly nervous individual in which the psychosomatic aspects of disease might well be present if not dominant. In order to describe our original contribution more clearly and adequately, some of our colleagues have referred to these findings as the Marshall-White Syndrome.

It is known that in conditions of stress, the microcirculation experiences increased activity from the sympathetic nervous system. The end result is the terminal arterioles tend to constrict, although these minute structures are affected by two conflicting stimuli, that is to say, the tendencies are to dilate and also to constrict these structures[2]. However, stress usually produces vasoconstriction in the microcirculation of the skin.

When one considers that patients with the Marshall-White Syndrome are under tension or emotional stress almost continually, it is not surprising that a vasomotor conflict is produced in their dermal areas as the result of these opposite sympathetic stimuli. But why more patients do not show such a syndrome under identical stress conditions cannot be answered satisfactorily at this time, any more than why some patients show entirely different patterns for sweating than do others under identical conditions of stress.

Report of a Severe Case

A middle-aged Caucasian male came to the office complaining of shortness of breath. He appeared to be worried and exceedingly nervous. He didn't wish to lie upon the examining table stating that he felt better sitting up. A rapid examination was performed immediately. His chest, lungs, heart and abdomen showed no pathologic findings, and the only finding of importance was that his pulse rate was 180/min. He was advised to enter the hospital for a complete examination and laboratory workup.

The patient was so dyspneic that he was placed in an oxygen tent and phenobarbital grs. ¾ was given by mouth. Within several hours, he was much better, and his pulse rate reduced to 100/min. He was given a thorough examination. His blood count, urinalysis, chest plate, electro-cardiogram and gastro-intestinal series (X-ray) were all within normal limits.

The only positive findings were noted on the palms of his hands and on the skin of his chest and abdomen. These changes were macular in type. They were blanched patches which very slowly changed their shape. One macular area would disappear while several others would appear. He exhibited marked tachycardia (180/min.) which obviously produced his severe dyspnea.

Upon questioning his wife, since he seemed adamant to co-operate by answering specific questions, she readily admitted that he experienced periods of severe insomnia.

After several days of psychiatric interviews, he finally admitted that he was undergoing marked periods of stress. He worked for a railroad company, and part of his job was to wander among boxcars at night in a heavily colored district. He worried about his safety, although he carried a revolver. The current racial crisis and the hours he had to spend alone at night in the colored district upset him greatly, although he never admitted this stress to his wife nor to anyone else.

Upon further questioning and rest, he appeared to undergo a welcomed catharsis since he began to relax both mentally and physically. Although the angiospastic intermittent macules of his chest became less noticeable, they are still present as are those on the palms of his hands.

His breathing and his pulse rate became normal with further rest, and he was discharged from the hospital in a few days.

Summary

We present the first known case where intermittent angiospastic macules were observed on a patient's chest and abdomen. Although sinus arrhythmia is a concomitant part of the Marshall-White syndrome, never previously have we observed any patient with such a rapid heart rate (180/min.).

His rapid pulse rate produced marked dyspnea which cleared rapidly with appropriate therapy. The severe emotional upheaval probably increased these neurocirculatory skin changes and the tachycardia after his emotional tolerance had been reached.

This syndrome is an example of the marked psychosomatic skin changes, evidenced by vasomotor conflict, which are produced as the result of intense emotional pressure upon an individual. These observable changes in the integument, the increased pulse rate and the resulting lack of proper sleep are important diagnostic signs which should alert any attending physician to the underlying malfunctionings and the internal struggle of the psyche and the soma in such a patient.

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Revised Manual Of Standards Published By ACOG

The Second Edition of the *Manual of Standards in Obstetric-Gynecologic Practice* was scheduled to be published March 1 by The American College of Obstetricians and Gynecologists. The manual is more comprehensive and three times greater in volume than its predecessor, the First Edition, which was published in 1959.

Compiled by the College's Committee on Professional Standards, with the cooperation of the Standards Committee of the American Association for Maternal and Child Health, numerous Fellows of the College, and other physicians, the Manual is designed for physicians, nurses, hospital administrators, and other personnel as a guide in providing proper facilities and good quality care for obstetric and gynecologic patients.

The Manual represents a compilation of recommendations and is not intended to be a rigid set of inviolate rules. Its authors have endeavored to codify what is currently regarded as proper obstetric-gynecologic care in well-organized hospitals throughout the country, with the realization that recommendations are subject to alteration by local conditions.

Included in the Second Edition are suggestions covering hospital facilities, equipment, and personnel; departmental organization; standards of prenatal, intrapartum, postpartum, and in-patient nursing care; standards of gynecologic practice; recommendation and referral; and radiation precautions.

Moreover, the Manual contains five appendices with recommendations on how to maintain satisfactory hospital records; what data should be collected; and the design of useful and complete forms. Definitions of terms and a list of reference works are also included.

The Manual will be distributed gratis to all Fellows and Junior Fellows early in March. Cost to non-fellows is $2.50 per copy with a 10% discount on orders of 25 copies or more. Orders, accompanied by check or money order, are now being accepted by the College, 79 West Monroe, Chicago, Illinois, 60603.

Recent Advances In Study Of Rheumatic Diseases: Pseudogout (Chondrocalcinosis Articularis)

Frank Lehn, M. D.

From the Division of Rheumatc Diseases, Department of Medicine, University of Alabama Medical Center, Birmingham, Alabama, made possible by NIH TI AM 5000-10 and Merck, Sharp and Dohme, West Point, Pa.

As new discoveries are made in the pathophysiology of disease, not infrequently new disease entities may themselves be recognized. One such recognition is that of pseudogout, a term recently introduced[1] to conceptualize a microcrystal-induced synovitis that is a separate and distinct entity from true gouty arthritis. McCarty and Hollander[2] found that acute gouty synovial effusions contain urate crystals, almost universally, as demonstrated by polarized light microscopy. This work led in turn to the discovery that some supposedly "gouty" patients' synovial fluids contained non-urate crystals.[1]

These non-urate crystals, when examined under light microscopy, were found to have both rodlike and rhomboid forms, whereas urate crystals uniformly are rodlike. The lengths of both types of crystals were approximately one to 25 microns. The non-urate, like urate, crystals were mostly intraphagocytic in the acutely involved joint while extracellular in the chronic state. Under polarized light microscopy, these crystals were found to exhibit weakly positive birefringence as opposed to the urate's strongly negative birefringence. When incubated with uricase, digestion of these crystals did not occur as does that of the urates.

Intra-articular injection of suspension of these crystals, like that of sodium urate, produced an inflammatory synovial reaction, associated with phagocytosis. The non-urate crystals, when subjected to analysis by infrared spectrophotometry, X-ray fluorescence and emission spectroscopy were found to be calcium pyrophosphate. These crystals were also found to produce a characteristic X-ray diffraction pattern,[3] thus giving a "common denominator" to a new syndrome. The neologistic appellation of "pseudogout" was tendered inasmuch as these patients had been previously thought to have gout clinically.

With the collection of a larger number[4] of patients the syndrome has now evolved with characteristic clinical, radiologic and pathologic parameters.

Clinically, pseudogout may sometimes be indistinguishable from gout, rheumatoid arthritis, osteoarthritis, or rheumatic fever. The distinctive clinical feature of pseudogout is an acute arthritis of larger joints, particularly the weight-bearing joints. The knee is affected predominantly, but ankle, hip, elbow, wrist, low back, cervical spine, medial collateral ligament of the knee, and calcaneocuboid joint involvements have been observed. Notably absent from the list of involved joints is the great toe. Not infrequently redness of the overlying skin has been noted.

The typical attack reaches its maximum intensity in 12 to 36 hours after inception of signs and symptoms. The patient usually first notices symptoms in the morning on arising and subsequent weight-bearing. The intensity of the pain is variable. Likewise, the length of duration of symptom is variable, ranging from 12 hours to four weeks. A tendency exists for joints previously involved to be the seat of subsequent symptoms. The occurrence of attacks in "clusters" is not uncommon.

There may be systemic manifestations such as low grade fever, leukocytosis, elevated sedimentation rate, and an increased concen-

tration of the serum alpha-2 globulin fraction. Aspirates of the joint fluid during the acute attacks may appear milky, opaque, or occasionally bloody and, under polarized light examination, the rod shaped or rhomboid (parallelepiped) crystals will be found.

Progression of the articular disease to osteoarthritis may occur. Flexion contractures have been noted, most commonly in the knee, less commonly in the fingers, wrists and elbows.

Certain systemic diseases have been found to be associated with pseudogout.[4, 5] Diabetes, hypertension and atherosclerosis are common but the mean age of the group described was 67 years, an age at which the occurrence of these diseases would not be unexpected. There may be an association with hyperparathyroidism,[4] for at least four patients with hyperparathyroidism and articular disease have been reported with X-ray changes typical of pseudogout.

Genetic factors may prove of some importance in that there has been noted a familial predilection in several of the cases thus far described.

Radiologically,[6] punctate aggregations of microcrystalline calcium pyrophosphate may be observed in the articular or fibrocartilage of the knee, ankle, hip, shoulder, elbow, wrist, lumbar and cervical intervertebral discs, symphysis pubis or the calcaneocuboid joint. A "screening" series for pseudogout has been suggested;[4] i.e., an anteroposterior (AP) view of each knee for menisceal calcification, AP view of the pelvis for calcification of the symphysis pubis, hips, and annulus fibrosis of the lower lumbar vertebrae and a PA of both wrists for calcification of the articular disc. If seen, these are thought to be among the most specific of radiological findings.

Pathologically the calcium pyrophosphate crystals are seen on histological sections of affected tissues and appear interlaced between fibrous tissue bundles distributed as miliary puncta ranging from 12 microns to 0.6 cm in size.

The pathogenesis of the microcrystalline precipitation is not known. The hypothesis that the crystal is a final common pathway of a number of metabolic disturbances such as "hereditary" pseudogout, diabetes, hyperparathyroidism or trauma has been advanced,[4] thus dividing pseudogout into primary and secondary categories, analogous to true gout.

McCarty[5] requires X-ray diffraction powder pattern identification of crystals from joint fluid or biopsy as calcium pyrophosphate before a "definite" diagnosis can be made. At present, the equipment necessary would seem to confine this means of identification only to large institutions until less complicated and less expensive apparatus is available.

The presence of non-urate crystals in synovial effusions, either intra or extra-leukocytic, that are not digested by uricase and the typical radiographic appearance are criteria for the diagnosis of "probable" pseudogout.

Acute synovitis of the knee or other large joints without elevation of the serum uric

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acid or a chronic synovitis, especially of the knees, with or without periodic exacerbations, are suggestive of "possible" pseudogout.

The treatment at present consists of rest and aspiration of the joint effusion with intra-articular injection of insoluble corticosteroid esters. Phenylbutazone, systemic corticosteroids, and salicylates in large doses are also effective. Colchicine has not proven to be consistently effective therapeutically and probably has no place in the therapy of pseudogout.

It seems worthwhile to mention that other micro-crystals are capable of producing inflammatory reactions when injected intra-articularly.[7,8] Among these are sodium orotate, calcium oxalate and occasionally corticosteroid preparations. These crystals are characterized by: (1) sparing solubility in water, (2) a certain size (0.5 to 20 microns), (3) Phagocytosis by poly- and mononuclear cells during the inflammatory response.

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Filmstrip On Glaucoma Available To Doctors

A filmstrip entitled, "Glaucoma Screening . . . A Three Minute Test For A Lifetime Of Sight," now is available to Alabama doctors without charge on a short-term loan basis.

The cause, nature, effect, symptoms and treatment of glaucoma are explained in the filmstrip as well as the incidence of the disease.

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One of the largest and most significant meetings on medicine and the law will be held in Las Vegas on March 11-13.

Sponsored by the American Medical Association and the American Bar Association, the National Medicolegal Symposium at The Dunes hotel will feature 41 participants.

They include: retired U. S. Supreme Court Justice Charles E. Whittaker; the Honorable Grant Sawyer, Governor of Nevada; Joseph F. Sadusk, Jr., M. D., medical director of the Food and Drug Administration and chairman of AMA's Committee on Medicolegal Problems; four judges; a law school dean; ten physicians; and 23 attorneys.

Speaking on behalf of the AMA-ABA Liaison Committee, co-chairmen Percy E. Hopkins, M. D., and Thomas Boodell, stated:

"This is the first time that the AMA and the ABA are jointly sponsoring a National Medicolegal Symposium. By combining the resources of our two organizations, we have been able to gather an impressive array of speakers.

"This promises to be one of the largest and most significant medicolegal meetings ever held. It will be a giant step in improving the administration of justice and in promoting harmonious relations between the medical and legal professions."

Systemic Manifestations Of Primary Pulmonary Malignancy

James R. Shamblin, M. D.*

No. 1 Dearing Place
Tuscaloosa, Alabama

Dr. Shamblin is a former Fellow in General Surgery, Mayo Clinic, Rochester, Minnesota.

Certain systemic syndromes have been found to be associated with carcinoma of the lung more often than could be expected by chance. Review of the recent literature finds reports of the following clinical pictures in patients with primary pulmonary malignancies: hypertrophic osteoarthropathy,[2] neuromuscular disease,[3] Cushing's syndrome,[5] carcinoid syndrome,[9], hyponatremia,[5] steatorrhea, hypercalcemia,[10] pseudohyperparathyroidism,[11] gynecomastia,[8] and fibrinogen deficiency.[8] The first four are the most common, and it is these that will be discussed.

I. HYPERTROPHIC OSTEOARTHROPATHY

Hypertrophic osteoarthropathy is that condition in which there is clubbing of the fingers and toes, periostitis with new osseous formation at the end of long bones, arthritis, and signs of autonomic disorders such as flushing, blanching, and profuse sweating.

Hippocrates described clubbing of the fingers in a patient with empyema in 400 B. C. Since then, clubbing has been described in a variety of conditions. It is thought to represent one manifestation of hypertrophic osteoarthropathy. Hansen[1] believes that clubbing occurs more often in diffuse pulmonary conditions such as bronchiectasis, while periostial proliferation is found more often with a localized lesion such as carcinoma.

Weirman, in studying 1,024 consecutive pulmonary resections at the Mayo Clinic, found the following incidence of hypertrophic osteoarthropathy:[2]

Lesion:	Resections:	Incidence %:
Pleural mesothelioma	14	57.1
Lung abscess	34	17.6
Cyst	30	10.0
Bronchiectasis	189	9.5
Malignant tumor	481	5.2
Tbc	157	0.6
Benign tumors, granulomas	119	0.0
	1,024	6.0%

Since this is a selective series, meaning patients undergoing surgery, the percentage of tbc and other inflammatory conditions is small. In most series, five to ten per cent of patients with carcinoma of the lung will have some degree of osteoarthropathy.

Pathologically, the long bones show round-cell infiltration and edema of the periosteum causing it to be elevated from the bone, with subsequent deposition of osteoid and mineralization of the new bony structure. The cortex of the bone shows resorption, and pathologic fractures are not uncommon. The synovial membranes around the joints are edematous and an inflammatory infiltrate is present. This may progress to synovial fibrosis. The appearance of clubbing is caused by edema of the soft parts surrounding the distal phalanges with thickening of vessel walls, cellular infiltration, fibroblastic proliferation and growth of new collagen tissue.

There are many causes of hypertrophic osteoarthropathy. Howell divides them into three groups: 1. hereditary, 2. idiopathic, and 3. secondary.[1] The most common secondary causes are pulmonary lesions and congenital

heart disease. Other causes are cirrhosis; diarrheal disorders such as chronic ulcerative colitis, regional enteritis, idiopathic steatorrhea, amoebic or bacillary dysentery; small intestine neoplasms; colon polyposis, and colon carcinoma; after thyroidectomy for Grave's disease and with hyperparathyroidism.

Unilateral clubbing is seen with aneurysms of the aorta, innominate or subclavian arteries, axillary tumors, subluxations of the shoulders, apical lung carcinoma and arteriovenous aneurysms of the brachial vessels. Unidigital clubbing may be due to Median nerve injury, sarcoidosis, or tophaceous gout.

The pathogenesis of osteoarthropathy is obscure. The following theories all have their champions: 1. liberation of toxins by the primary lesion(s), 2. arterial anoxemia, 3. vascular stasis from elevated venous pressure, 4. osteoblast-stimulation by a substance released from the pluripotential mesothelial cells of the pleura, 5. endocrine imbalance, 6. release of local toxins from a circulatory disorder, and 7. an obscure autonomic reflex at the site of the underlying disease. Experimental animals who have a pulmonary artery—left atrial shunt regularly develop osteoarthropathy which increases as the cardiac output increases. Several observers have found that denervation of the pulmonary hilum or vagotomy in inoperable pulmonary carcinoma was associated with improvement in the symptoms and signs of arthropathy.

Pulmonary osteoarthropathy may be asymptomatic or disabling. The symptoms are similar to rheumatoid arthritis, in fact, many patients are treated for this before the underlying pathology becomes evident. Arthralgias, frequently migratory, affect the ankles, knees, wrists, and hands. This is most likely to occur with mesotheliomas or carcinomas. Tenderness may be present over the distal portions of the long bones in the extremities, but may occasionally involve other bones as well. The condition may progress to crippling immobility of the joints. Arthralgias may occur with X-ray findings of bone disease, disappear after resection of a lung malignancy, and recur when the tumor recurs. After pulmonary resection the arthralgia frequently subsides dramatically, but the clubbing resolves over a longer period of time.[2]

II. NEUROMUSCULAR DYSFUNCTION:

Several cases of a myasthenia-like syndrome associated with pulmonary malignancies have been published in the British literature since 1948. In July, 1960, Rooke and others at the Mayo Clinic reviewed 19 cases of unusual myasthenia and proposed the name, "Myasthenic syndrome sometimes associated with small-cell bronchogenic cancer."[3] They feel that the clinical characteristics are sufficiently distinctive to warrant placing them in a definite syndrome. These characteristics are: 1. weakness and fatigability of the proximal muscles of the extremities, especially those of the pelvic girdle and thigh, 2. a temporary increase in muscle strength in response to voluntary exercise of a few seconds, 3. a decrease or absence of the muscle stretch reflexes, 4. a relatively poor response to neostrigmine, 5. marked sensitivity to d-tubocurarine, 6. dryness of the mouth, 7. loss of potentia, and 8. peripheral paresthesias. These findings are different from those of the typical myasthenia gravis, especially in the distribution of muscle weakness and the response to voluntary exercise. Electromyographic findings differ from those of myasthenia only in a quantitative manner.

Each of these 19 cases presented at the Mayo Clinic with a chief complaint of muscle weakness. None mentioned pulmonary symptoms except on direct questioning. Seventeen of the cases were men. The cases were divided into three groups. Group A, seven cases, had an abnormal chest X-ray on the initial exam, but had minimal pulmonary symptoms. All seven patients had proven oat-cell carcinoma and five had died of their disease at the time of the report. Group B, seven cases, had a negative initial chest X-ray, but all subsequently were proven to have a pulmonary malignancy; four having oat-cell cancer, one squamous-cell cancer, one reticulum-cell sarcoma, and one unidentifiable

malignancy. Five are dead of their disease, the longest survivor being three years after onset of muscular weakness. Group C, five cases, had a clinical picture corresponding to the other two groups, but had a negative initial chest X-ray and subsequent studies including sputum, X-rays, etc., have revealed no evidence of malignancy, with three patients having been followed as long as six years. They have been treated with neostigmine, but the response has been poor.

Muscle biopsy in one case with malignancy was nonspecific and histologic exam of a peripheral nerve in another case showed moderately severe demyelinization. Only one case had surgery. A mediastinal mass was found and removed, but the primary was not found. At follow-up exam three months post-operatively, there was clinical and electromyographic evidence of improved muscular function.

Several theories have been advanced to explain the inter-relationship between the pulmonary malignancy and the myasthenic syndrome. 1. Toxic excretion by the tumor—55 patients with proved malignancy including 29 with oat-cell cancer had neurologic and/or myographic exam. None showed neuromuscular disease. 2. The possibility of the oat-cell cancer being an atypical thymoma was discounted by reviewing the pathologic specimens. 3. A third possibility, and one so far not proven or disproven, was that a virus or some other agent caused both the carcinoma and the myasthenic syndrome.

Heathfield and Williams found 11 cases in the literature of peripheral neuropathy and bronchogenic carcinoma and added four of their own.[4] Eleven cases were of the oat-cell variety, three were squamous, and one was undifferentiated. Some cases had the neuropathy for as long as three years before the onset of symptoms related to the carcinoma. They found four types of involvement. Sensory neuropathy was present in two of their cases and consisted of changes primarily in the lumbo-sacral and cervical roots with severe sensory atoxia, "glove and stocking" anesthesia, and root pains. Pathologic exam reveals symmetrical and extensive degeneration of posterior columns and posterior nerve roots. One of their cases had a mixed motor and sensory involvement and this was the most common form in the collected cases. The motor symptoms predominated, and two patients have died from respiratory muscle paralysis. They had one case of pure myopathy in the lower limbs. A fourth category, that of cerebellar degeneration, was found in the collected cases, and has also been described with cancer of the ovary, breast, and uterus. All cases had nodal metastases and some had distant metastases. Treatment with large doses of B vitamins had no consistent effect on the neuropathy. They speculate that the neuropathy is on a metabolic basis secondary to the pulmonary tumor.

III. ADRENOCORTICAL HYPERPLASIA:

Adrenocortical hyperplasia is found in a high percentage of patients dying of carcinoma. In most of these, there is no clinical evidence of adrenal hyperfunction, but cases have been reported in which Cushing's syndrome was associated with carcinoma, especially that of the thymus, thyroid, stomach, pancreas, prostate, ovary and breast. In the past ten years, more than 20 cases of adrenocortical hyperfunction and bronchogenic cancer have been reported. Vogel at the Mayo Clinic reported a case of acute Cushing's syndrome with small cell carcinoma and reviewed the literature.[5] He found 23 cases, 11 of whom had typical Cushing's syndrome, the remaining 21 having chemical or histological evidence of adrenocortical overactivity. Twenty-one of his total of 24 cases had the small-cell type carcinoma of the lung.

The adrenal hyperfunction may present in two forms. In the first, typical Cushing's syndrome is present with "moon facies," enlarged cervical fat pad, purple striae, hypertension, and diabetes mellitus. The other clinical picture consists of progressive weakness, hypokalemic alkalosis, muscle wasting and rapid death, a symptom complex similar to hyperaldosteronism.

Bornstein analysed 17 cases from the litera-

ture and found that males outnumbered females almost three to one and that the patients' average age was 51 years.[6] These statistics resemble the expected findings of carcinoma of the lung, not Cushing's syndrome. The patients' presenting complaints were weakness, polyuria and polydipsia, edema, and mental confusion. Most did not appear Cushingoid on first examination, but several developed the typical features while being observed. Since most of the patients died within three months of the onset of symptoms, it has been speculated that they did not live long enough to develop the full-blown syndrome. Of interest is the fact that while the five-year survival rate of small-cell cancer without adrenal hyperfunction is 15 per cent, and the five-year survival in untreated Cushing's syndrome without malignancy is 50 per cent, the patients in Bornstein's series were all dead by one year after onset of symptoms.

The diagnosis of Cushing's syndrome is facilitated by finding elevated 17-ketosteroids, or glucocorticoids. In the reported cases, these were elevated in every case in which they were measured but one. Another finding in this association has been a severe hypokalemic alkalosis. In fact, Kovach and Kyle state that bronchogenic carcinoma should be suspected in patients with Cushing's disease who have a low potassium, low chloride and elevated bicarbonate.[7]

In the cases that came to autopsy, metastases to the adrenal were found in ten of 17 patients. Most of the glands were large, from 23-86 gm., but some were normal in size. Hyperplasia of the cortex was present in cases with or without metastases and involved primarily the zona reticularis and fasciculata, with compression and atrophy of the zona glomerulosa. This finding is interesting in view of the fact that the zona glomerulosa is thought to secrete aldosterone and many of the patients have some of the chemical and clinical findings of hyperaldosteronism. The zona reticularis cells are believed to secrete androgens and estrogens, but none of the patients in this group were thought clinically to have evidence of secondary sexual changes on this basis, although Hardy has reported two cases of gynecomastia associated with bronchogenic cancer.[8]

The hyperplastic cell changes were quite similar to those found in patients who had been treated with ACTH.

Several mechanisms have been proposed for this unusual association. Some have thought that the adrenal cortices were "irritated" by metastases, but this seems untenable for two reasons. First, several patients had no adrenal metastases; and secondly, 50 per cent of the patients with cancer of the lung in some series are found to have adrenal metastases, but hyperfunction of the adrenal is exceedingly rare. Other authorities have thought that the primary tumor may secrete a steroid-like substance. If this were true, it would seem that the adrenal glands would be hypoplastic instead of hyperplastic. Most accumulated evidence suggests that the tumor causes excess ACTH production by the pituitary with resultant adrenal changes. One case was found to have an elevated level of plasma ACTH. Another case was treated with a synthetic steroid which decreased the urinary 17 hydroxycorticosteroid output. In a third case, pituitary irradiation gave temporary relief from the symptoms of hypercortisonism. In none of the autopsy cases have specific changes been found in the pituitary. In summary, it is not possible to establish which of the two conditions came first, the bronchogenic cancer or the adrenal hyperplasia; but the two conditions together produce a disease of acute onset and rapid fatality.

IV. CARCINOID SYNDROME:

The carcinoid syndrome was described in 1952 and 1954 by Thorson and Bioack in patients with metastatic carcinoid tumors of the intestine.[9] The syndrome is due to the systemic effects of 5-hydroxytryptamine (serotonin) and presents any or all of the following features—diarrhea, flushing of the face and upper trunk, respiratory distress resembling asthma, right-sided cardiac lesions with or without failure, enlarged liver, peptic ulcer, and arthritis.

Since the liver plays the primary role in detoxifying serotonin, it is necessary for intestinal carcinoids to metastasize to the liver and empty their serotonin content into the hepatic vein in order to produce the full blown carcinoid syndrome. This anatomic arrangement enables the serotonin to escape the detoxifying effect of the hepatic cells.

The lungs also serve to detoxify serotonin, but to a lesser extent than the liver. Therefore, pulmonary tumors producing serotonin deliver their product into the systemic circulation without first passing through potential sites of detoxification. This can occur with metastatic pulmonary nodules from primary bronchial adenomas.

Bronchial adenomas are divided into two types, cylindromas (15 per cent) and carcinoids (85 per cent). Ten per cent of bronchial adenomas have been found to metastasize, although usually only to regional nodes, but not distantly.

Bronchial carcinoids were so-named because of their resemblance to intestinal carcinoids. The most common concept of the origin of bronchial carcinoids is that they arise from the mucous glands in the bronchi. Jackson and Konzelman have suggested that they may arise from neural elements in the bronchi, giving them a closer relationship to the intestinal carcinoids than has previously been appreciated.[12]

In 1956, Kincoid-Smith and Brossy reported a case of bronchial adenoma, with liver metastases and diarrhea occurring six years after removal of the primary, but 5-HIAA levels were not measured.[9] Warner and Southern in 1958 reported two cases of atypical bronchial carcinoid with liver metastases that had most of the features of the classical carcinoid syndrome. Luparello in 1961 found seven reported cases of functioning bronchial carcinoid and added his own case.[13] Six of the eight cases had histologic proof of liver metastases and a typical picture clinically. Two other cases had atypical features, but the primary lesion in both cases had an elevated serotonin content. Three months to six years had elapsed in these cases between the time of pulmonary surgery and the onset of the carcinoid syndrome. Luparello attributes this to the slow growth of the tumors and the delay in occurrence of hepatic metastases.

Diagnosis of the carcinoid syndrome is based on the clinical picture and the finding of elevated blood levels of serotonin or urinary 5-hydroxy indole acetic acid, the breakdown product of 5-hydroxytryptamine. Warner believes that the qualitative test for 5-HIAA is specific for metastatic carcinoid.

Functioning bronchial carcinoid is compatible with a long, but uncomfortable life. Many authorities recommend resection of the involved liver if feasible, to reduce the level of circulating serotonin. Escovitz, however, believes that no simple relationship exists between the blood levels of serotonin and the symptoms.[12] Rauwolfia has been shown in animals to mobilize serotonin from the intestine and increase the urinary excretion of 5-HIAA. One patient in the series had a remission of symptoms while being treated with Rauwolfia only to have a recurrence of symptoms upon withdrawal of the drug.

Of the many drugs tried for symptomatic relief, only Chlorpromazine has been of reasonable benefit.

Escovitz reported the interesting case of a 35-year-old male with bronchial carcinoid with oat-cell features who presented with the carcinoid syndrome and Stokes-Adams attacks.[12] Later in his course, he developed symptoms of hypercortisonism and his Stokes-Adams attacks diminished. In six cases in the literature Prednisone has been found to decrease the incidence of Stokes-Adams attacks. At autopsy, this patient had wide-spread systemic metastases from the carcinoid including the adrenal cortices and myocardium, but no obvious masses were present in the liver. The adrenal cortices were hyperplastic.

V. SUMMARY:

Besides the signs and symptoms of local disease, pulmonary tumors may produce many different and bizarre systemic effects. Among the most common are pulmonary osteoarthropathy, neuromuscular dysfunc-

tion, adrenocortical hyperplasia, and carcinoid syndrome. The occurrence of these symptoms, which are otherwise unexplained, should lead to a search for a primary pulmonary malignancy.

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Pharmaceutical Group Asks Changes In Medicare Bill

WASHINGTON, February 12—The Pharmaceutical Manufacturers Association has recommended that H. R. 1, 89th Congress, the Medicare Bill pending in the U. S. House of Representatives be amended to allow physicians more freedom in selecting the drugs to be used on patients over age 65.

Dr. Austin Smith, PMA president, suggested the changes on behalf of the pharmaceutical industry in a letter to Chairman Wilbur Mills of the House Ways and Means Committee.

One proposed revision would apply to Subsection 1806 (j) of the bill, which defines the terms "drugs" and "biologicals."

"We believe this language is unintentionally restrictive," Dr. Smith wrote, "that it will prevent beneficiaries under the program from receiving optimal health care; that it will limit the physician in the practice of his profession; and that it will be difficult of interpretation."

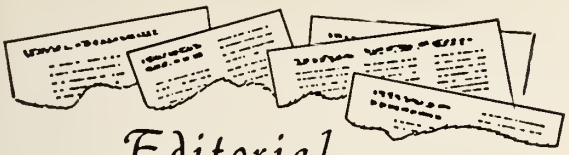
Smith said this section which defines the drugs to be covered under the program, would prevent a doctor from including some medicines which are valuable and well-established and would prevent use of "a number of newer, more effective drugs."

The other change which Smith recommended applies to Subsection 1809 (b) of the bill concerning costs.

"Under this provision," Smith wrote, "the Secretary (of the Department of Health, Education, and Welfare) could, by regulation exclude certain drugs on the basis of cost alone, whereas the principal issue should be the product's effectiveness and qualitative characteristics."

Internists Recommend Improved Medical Library Facilities

The American College of Physicians (ACP) has recommended the enactment of a federal law to expand and improve medical library facilities throughout the United States.



Editorial COMMENT

It's Time To Protect Against Misuse Of Good Medicine

EDITOR'S NOTE: *Since the following editorial was sent to the printers, the FDA has ordered restricted the sale of methamphetamine inhalers to prescription only.*

George Pharrick, FDA Commissioner, said that his agency had received a very sharp increase in reports of abuse of these agents over previous years.

Not too many months ago the press and national magazines were carrying stories of the abuse by children and teenagers of certain volatile glues. The glue-sniffing child was a problem in the elementary schools, and the glue-sniffing teenager was a source of trouble to the police and juvenile authorities. This ingenuity of youth, per se, can hardly be condemned. This perseverance even, it might be said, serendipity, on the part of the discoverers of this new sensation, is in the highest spirit of pure science. Unfortunately, however, the discoveries were detrimental, rather than beneficial, and the program of education had to be mounted to combat the problem. Recently, it has been apparent to physicians of Alabama and to the police authorities, that a new source of trouble had arisen among certain groups of teenagers and young adults, similar to the misuse of the liquid cements and volatile glues. The psychotoxic drugs, and other drugs having effect on the central nervous system, are being misused. Any drug, either habituating or addicting, which modifies behavior may fall into this group, but the special problem now facing the authorities in at least one major Alabama city, concerns the misuse of drugs and drug mixtures which are exempt from coverage by law. Narcotics are already well covered by the Harrison Narcotic Act. Certain states have seen fit to control amphetamines and barbiturates, and it is generally held that these do not now constitute a serious threat to the health of the people. Tranquilizers, antihistamines, phenylephrine Hcl, alcohol, and codeine make a potent mixture. Taken under the direction of a physician they are highly efficacious and beneficial. However, the abuse of these substances especially in combinations can cause serious difficulties.

It was noted by a very observant policeman that there were numerous empty medicine bottles, all similar, found on the sidewalk and in the alleys and gutters around several notorious beer parlors. This officer also noted that there was a considerable increase in misbehavior among the teenagers frequenting this neighborhood. This is what was occurring. The largest boy in the group would go into a pharmacy and purchase a four ounce bottle of cough medicine containing one or more antihistamines, phenylephrine hydrochloride, and codeine. These boys had discovered which cough medicines by brand names contained the proper ingredients to give them their "buzz." Each boy would take approximately one ounce of the mixture and follow this with a can of beer. They would move on to another drug store, repeat the purchase, again take approximately an ounce of the cough medicine and again follow it with one or more cans of beer. The

pharmacological results varied somewhat from individual to individual, but the general pattern was that of a combination of alcoholic intoxication, and a feeling of euphoria. Some imbibers became belligerent, others extremely mischievous, and all highly susceptible to encouragement toward violation of the law.

At this time one may only speculate as to which particular drug is the greater offender, but perhaps it is the combination especially with the addition of alcohol that causes the real problem. The potentiating effects of certain tranquilizers on alcohol is well known. Similar experiences have been noted with antihistamines, and the phenylephrine hydrochloride sniffer is not new to practicing physicians.

Just as there is no law against the sale of the volatile cements, there is no law against the sale of this very good cough medicine which serves a very good and useful purpose when properly used. There is a law against the sale of beer to minors, but they seem always to find a way around it. In the 88th Congress S-2628 which proposed certain amendments to the Federal Food, Drug, and Cosmetic Act, considered national legislation for the control of psychotoxic drugs. At that time it was felt that the control of these items should be left to local cities and states. It becomes apparent, therefore, that a program of education and appropriate local and state laws may be needed to protect, not only the rights of the physicians and pharmacists, but the average citizen who may be harmed by misuse and abuse of good medicines.

MEDICARE AS SEEN BY HEW

A recent conference of the American Hospital Association was treated to a brief glimpse of the government's plan for administering a federal hospital insurance program for the aged if that socialistic bill should ever be passed by Congress.

The speaker was Mr. Arthur E. Hess, Director of the Division of Disability Operations of the Social Security Administration. In his opening remarks he observed that "if such a program (medicare) is enacted this year and goes into effect in 1966, it is none too early to broaden the base of discussion between government and hospital people."

From that point, he proceeded to slowly but surely unveil HEW's scheme for ultimately controlling hospital services and charges.

To the credit of the Hospital Association, it must be reported that they did not swallow "in toto" his rosy-hued picture of that glorious day when government administrator and hospital administrator will march down that road together toward the Utopian Great Society.

A dangerous thread of forced compliance was woven throughout Mr. Hess' speech, and it quickly became apparent to the hospital administrators that when he used such words as accredited there was immediately posed the possibility of non-accreditation should the hospital displease the bureaucrats at home or in Washington who would be administering this program.

The speaker glossed over the many exposed shortcomings in the King-Anderson plan and hardly mentioned the booby trap agreement that hospitals and other providers of services will be asked to make with the social security program. He came perilously close to exposing his hand when he stated that "the government could also terminate (the agreement) but only after due noted and stated causes, such as refusal to furnish necessary information, or inability to comply with the agreement."

It can be speculated that, once the hospital administration is enmeshed in government red tape, its business office will hardly have time left to order emergency supplies.

Hospital administrators are unlikely to swallow the King-Anderson "medicare" program without a great deal of gagging. When they look sufficiently long at the fine print

LETTER TO THE EDITOR

William L. Smith, M. D.
19 South Jackson Street
Montgomery, Alabama

Dear Bill:

It is with considerable pleasure that I have just read and then re-read your editorial comment entitled "Fledgling ALAPAC Tries Its Wings." I think this is a particularly good analysis of the role which was played in Alabama this past year and there were many points, which if adhered to, will make our program much more effective in the years to come.

At the national level we have observed that to be very effective there must be close cooperation between the state Board of Directors and the district PAC's. The district PAC is extremely necessary and unless this is well organized and financed the movement will fail to progress as it certainly should do with adequate knowledge and organization.

Again let me compliment you on this editorial and I think it will be well read and observed throughout our state.

With kindest personal regards and looking forward to seeing more excellent editorials of this type, I am

Sincerely,
M. Vaun Adams, M. D.

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on such matters as "first day deductibles" to be charged against the indigent patient, "fiscal intermediaries," "boards of review," provisions for periodic inspections, tangle plans for reimbursement, and a dozen other pitfalls, they are likely to raise their voices even louder in protest against the King-Anderson bill.

Just one sentence in Mr. Hess' speech should f l a s h on the red warning lights in every hospital in this country. That was, "of course, the Social Security Administration would still have the over all responsibility for sound administration of the program and would have to retain the authority for final administrative decision."

Purchase Of Drugs— "An Unwanted Event"

One of the best buys (if indeed not *the* best) in our country today is the purchase of drugs. Considering what one gets for his money, namely, better health and/or less suffering, the cost is most usually well worth every penny spent. It is most unfortunate though that many people believe quite differently. Whatever their reason may be, there frequently lies hidden that unpleasant fact of paying for an unwanted event.—Joseph P. Schaefer, in *New Physician,* 14: 1, (Jan.) 1965.

Wanted—Physicians For Drug Research

It is common knowledge that the pharmaceutical industry is faced with a significant issue in the shortage of qualified investigators. Drugs are becoming more and more complex and the use of the general doctor, without specific experience in clinical investigation, in testing drugs in his office in the midst of a busy practice is probably coming to an end. The need for training of physicians in the drug research field has reached a critical stage, and this problem must be met by the joint efforts of government, industry, and the scientific community.—Joseph F. Sadusk, Jr., M. D., in *Bulletin of the American College of Physicians,* 5: 6, (Nov.-Dec.) 1964.

Hysteria—Pandemonium—Pressure

Legislation that is conceived and enacted in an atmosphere of panic is usually ill-advised and may be disastrous. This statement applies to the passage of the Kefauver-Harris amendment to the Food, Drug and Cosmetic Act. It had its origin in the hysteria and panic of the thalidomide tragedy, it was nurtured and developed in the pandemonium of the biased hearings before the Kefauver Committee of the Senate, and through the pressure of an impetuous administration, was enacted into law.—John C. Krantz, Jr., Ph. D., in *Military Medicine,* 130: 1, (Jan.) 1965.

Allergic Reactions Seen In Intravenous Urographies

In a five-year study at Ochsner Clinic in New Orleans allergic reactions were recorded in only 1.68% of 10,000 consecutive excretory urographies, according to a paper in *Southern Medical Journal* (57: 1401, 1964).

An overall incidence of 8.53 per cent of untoward reactions was observed following the procedure, which is called "an important, widely used diagnostic procedure in medical practice today." The contrast agent used in the study at Ochsner Clinic was Hypaque (diatrizoate sodium, 50 per cent). The investigating team consisted of Drs. William P. Coleman, Seymour F. Ochsner and Ben E. Watson.

Noting that previous reports indicated a higher incidence of reactions in persons with a personal or family history of allergy, they say: "Surprisingly, more than twice as many allergic reactions occurred among the group with a negative history of allergy than those with a positive history."

Commenting on their own findings as well as published reports generally, the Ochsner Clinic group says that "reactions occur occasionally," and are mostly mild.

New Compact, High-Energy Medical Lab Tool Introduced

Dynasonics Corporation has announced development of an extremely compact, high-intensity ultrasonic applicator designed to offer medical laboratories a quicker and more efficient method of accomplishing emulsifying, homogenizing, atomizing and other important investigative and research functions.

The device—called "Sonitool" is a completely portable instrument, which can be hand-held in operation. It is operable by non-skilled personnel, and free of operational hazard.

Included in its capacities is ability to quickly emulsify so-called "unmixable" liquids, and to isolate or break down cells in tissue culture.



I want to see you gain weight, Miss Lee. What are you doing for dinner tonight?

(Nebraska State Medical Journal)

Comparison Study Cites Winstrol's Ability To Build Tissue With Little Masculinization

Winstrol (stanazolol), a synthetic steroid, produces very satisfactory results in building up needed body tissue with a minimum of masculinizing action, according to results of studies of anabolic steroids published in *Clinical Medicine* (71:2089, 1964).

The other steroids discussed were norethandrolone, methandrostenolone and oxymetholone. In all four compounds the anabolic functions are significantly dissociated from their androgenic action, points out Dr. M. L. Tainter and co-workers at the Sterling-Winthrop Research Institute, Rensselaer, N. Y.

Reviewing published clinical reports, they say Winstrol was found "to have the most complete separation of these two modalities of action so that it can be used in full anabolic doses with very little accompanying sex-linked side effects."



Your Journal

Neither First . . . Nor Last

At the request of the State Medical Journal Advertising Bureau, Inc., which obtains national advertising for this and all state medical journals, we ran a readership survey in our December issue designed to obtain data which will assist in selling additional advertising space. Every other state medical journal published the same questionnaire, and those returned by the readers will be forwarded to the New York advertising offices of SMJAB for analysis.

In the two months since the questionnaire was published in this journal, only 65 have been returned from the 2,300-odd doctors in Alabama. Whether this indicates that only three per cent of our membership reads the *Journal* or that Alabama doctors are too busy to answer questionnaires remains to be determined. However this may be, we hereby extend our grateful appreciation to the 65 doctors who did comply with our request and assure them that the information they gave us was most valuable.

We asked you to rate our scientific papers; and of the 65 replies received, 43 rated them fair, and 12 rated them excellent.

Scientific papers were the most popular feature of the *Journal,* followed by state news, editorials, the Association Forum, and Public Health articles in that order.

There was a wide diversity of opinion over what should be added to the *Journal* to make it better; eight respondents called for more state news, 6 wanted better scientific articles, 5 asked for clinical-pathological conferences, and 4 wanted more articles on local medical problems being solved by the members.

There were also suggestions that the *Journal* should carry more editorials, more political news, more stories of the Health Department and the Medical College, letters to the editor, classified ads, a better calendar of future meetings, and one asked us to encourage differences of opinion which could be debated in the columns of the *Journal.*

General practitioners were far in the lead in the number of responses. Following were Internal Medicine, General Surgery, and Pediatrics, in that order.

The results should be most gratifying to our loyal local advertiser—Durr Surgical



The Board of Trustees of the Medical Association of the State of Alabama held its February meeting recently in the Association offices at Montgomery. Shown in the above photo are, left to right, Dr. S. Buford Word of Birmingham, Dr. R. M. Miller, Jr., of Decatur, Dr. A. F. Toole of Talladega, Jerry Gould, field representative of the AMA, Dr. J. C. Donald of Mobile, Dr. J. M. Chenault of Decatur and Dr. W. L. Smith of Montgomery. In the inset is Association President, Dr. E. B. Glenn of Birmingham.

Discussing various problems below are, left photo, Dr. H. E. Askin of Alexander City, Dr. W. A. Daniel, Jr., of Montgomery, Dr. H. G. Hodo, Jr., of Fayette, Dr. S. J. Campbell of Birmingham and Dr. M. Vaun Adams of Mobile. Shown at lower right are Dr. Adams, Dr. E. F. Porch of Arab, Dr. Toole and Dr. Luther Hill of Montgomery, a member of the Board of Censors.





Supply. Forty-nine doctors said they had referred to or purchased from a local advertiser in the *Journal*, and an overwhelming proportion of these specified Durr.

In the percentage of readership given to your *Journal* in comparison with other major medical publications, we shared better than we anticipated. While only one respondent said that he rated our journal first, 42 rated their specialty journals first. We were rated second by 9 readers, third by 6 readers, fourth by 13 readers, fifth by 10 readers, sixth by 10 readers, and we were not rated at all by 15 readers.

The *Journal of the American Medical Association* was rated first by 8, second by 13, third by 11, fourth by 12, fifth by 4, and sixth by 5.

Surprisingly, the *New England Journal of Medicine* won as many first place votes as JAMA (8). They also showed strongly in second, third, fourth, and fifth places. Also rated highly were *Modern Medicine* and *Medical Economics*.

To all those who took the trouble to answer our questionnaire, we again express our appreciation in the hope that, through your efforts, you will be rewarded by a better state journal.

PROGRAM

Of The 104th Annual Session

Of The

MEDICAL ASSOCIATION OF THE STATE OF ALABAMA

Birmingham

Parliament House

April 22, 23, 24, 1965

GENERAL INFORMATION

All business sessions of the meeting will be held at the Parliament House Motor Hotel.

Scientific sessions will be held at the Parliament House Motor Hotel, the Guest House Motor Inn, and the Liberty National Building Auditorium.

HOST TO THE ASSOCIATION

The Jefferson County Medical Society

OFFICERS

William E. Lawrence, *President*
Charles W. Neville, *President-Elect*
Arthur I. Chenoweth, *Vice-President*
Hal Ferguson, *Secretary-Treasurer*

THE FIFTY YEAR CLUB

According to custom, physician members who graduated fifty years ago will be honored by the Association at this meeting.

THE FIFTY YEAR CLUB

(To whom Certificates of Distinction will be awarded Friday morning, April 23.)

William Henry Beddow	Birmingham
John Mac Bell	Mobile
Julius Orville Belue	Athens
Samuel James Calhoun	Langdale
Alfred Carraway	Alabama City
H. Earle Conwell	Birmingham
Drayton Howard Doherty	Selma
Rayford Hodges	Scottsboro
Aaron Simeon Hutto	Pinson
Herbert James Lewis	Birmingham
Clifford Vernon Mayhall	Athens
Timothy Cleveland McCay	Pinson
Leon Victor McVay	Mobile
Charles Smith Moss	Carbon Hill
John Doke Sherrill	Birmingham
James Alexander Ussery	Courtland

PROGRAM COMMITTEE

E. B. Glenn, *Chairman*
W. B. Frommeyer, Jr., *Medicine*
James M. Mason, III, *Surgery*
S. Buford Word, *Obstetrics and Gynecology*

COMMITTEE ON ARRANGEMENTS

S. J. Campbell, *Chairman*
Hal Ferguson, *Hotels and Liaison*
Samuel Cohn, *Speakers*
Gilder Wideman, *Halls and Registration*

TRANSPORTATION

J. Frank Trucks, *Chairman*
Lamar Campbell — M. B. Sullivan
Donald Slappey — J. C. Chambers

VACANCIES IN THE COLLEGE OF COUNSELLORS

1st Congressional District—2. Cecil E. Kimbrough has completed his first term of seven years. Arthur A. Wood has completed his first term of seven years.

3rd Congressional District—1. Samuel W. Windham has completed his first term of seven years.

5th Congressional District—1. James E. Cameron has completed his first term of seven years.

7th Congressional District—1. Murray C. Hollis has completed his second term of seven years.

9th Congressional District—4. Paul W. Burleson has completed his first term of seven years. Benjamin M. Carraway has completed his first term of seven years. William E. Coleman has completed his first term of seven years. Joseph A. Cunningham has completed his first term of seven years.

PROGRAM

Thursday, April 22, 1965

Parliament House

E. B. Glenn, M. D., President, Presiding

9:00 A. M.

Call to order

Invocation—*Rev. John Turner*, Church of The Advent, Birmingham

9:05 A. M.

Welcome Addresses—
Mayor Albert Boutwell, Birmingham
William E. Lawrence, M. D., President, Jefferson County Medical Society

ORIENTATION PROGRAM

James G. Donald, M. D., President-elect, Presiding

9:10 A. M.

Organizational Structure of the Medical Association of the State of Alabama, *J. O. Morgan, Sr., M. D.*, Gadsden

9:20 A. M.

County Medical Society Organization and Activities
A. Urban—*S. J. Campbell, M. D.*, Birmingham
B. Rural—*E. L. Strandell, M. D.*, Brewton

9:30 A. M.

State Board of Censors, *J. O. Finney, M. D.*, Gadsden

9:40 A. M.

Activities of State Board of Health and County Health Departments (Includes TB, Cancer, VD, Laboratory, etc.), *Ira L. Myers, M. D.*, Montgomery

10:00 A. M.

BREAK—View Exhibits

10:15 A. M.

Ethical Problems, *Arthur I. Chenoweth, M. D.*, Birmingham

10:25 A. M.

Blue Cross-Blue Shield of Alabama, *Mr. William Mandy*, Birmingham

10:35 A. M.

The Kerr-Mills Program for Aged and Medically Indigent of Alabama, *J. J. Kirschenfeld, M. D.*, Montgomery

10:45 A. M.

Maternal and Child Health, *Harold Klinger, M. D.*, Montgomery

10:55 A. M.

Woman's Auxiliary, *Mrs. L. H. Clemmons*, President, Cullman

11:00 A. M.

Smoking and Health, *R. K. Oliver, M. D.*, Tuscaloosa

11:10 A. M.

S. Richardson Hill, Jr., M. D., Dean, Medical College of Alabama, Birmingham

11:20 A. M.

AMPAC, *Donald E. Wood, M. D.*, Immediate Past Chairman, AMPAC Board of Directors, Indianapolis, Ind.

11:35 A. M.

President's Message, *E. B. Glenn, M. D.*, President, Birmingham

12:30 P. M.

LUNCH—The Guest House Motor Inn

SCIENTIFIC PROGRAM

Surgical Section

Thursday, April 22, 1965

Parliament House

S. J. Campbell, M. D., Vice-President, Presiding

"OCCLUSIVE VASCULAR DISEASE"

2:00-2:20 P. M.

Thrombophlebitis and Its Sequelae, *W. Sterling Edwards, III, M. D.*, Professor of Surgery, Medical College of Alabama, Birmingham

2:20-2:40 P. M.

The Diagnosis of Pulmonary Embolism by Radioisotope Scanning, *Gerhard F. Fueger*, M. D., Division of Nuclear Medicine, Department of Radiology and Radiological Science, Johns Hopkins Medical Institutions, Baltimore, Maryland

2:40-3:00 P. M.

Plication of the Vena Cava, *Frank C. Wilson, Jr., M. D.*, Surgeon, Birmingham

3:00-3:20 P. M.

Surgery of Pulmonary Embolism, *William L. Glenn, M. D.*, Professor of Surgery and Chief of the Cardiovascular Section, Yale University School of Medicine, New Haven, Connecticut

3:20 P. M.

BREAK—View Exhibits

3:30-5:00 P. M.
PANEL

Medical and Surgical Aspects of Occlusive Vascular Diseace—Moderator: *T. Joseph Reeves, M. D.*
Panelists: *William L. Glenn, M. D., Jon V. Straumfjord, M. D., G. F. Fueger, M. D., Frank C. Wilson, Jr., M. D., W. Sterling Edwards, III, M. D., E. E. Eddleman, Jr., M. D., Anthony P. Fletcher, M. D.*

Medical Section

Thursday, April 22, 1965

Liberty National Building Auditorium

W. B. Frommeyer, Jr., M. D., Presiding

2:00-2:20 P. M.

Diagnostic Utility of Lactic Dehydrogenase (LDH) Isoenzyme for Myocardial Infarctions, *Jon V. Staumfjord, Jr., M. D., Ph. D.*, Director, Clinical Laboratories and Schools of Laboratory Sciences, University Hospital and Hillman Clinic; Associate Professor of Pathology, University of Alabama Medical Center, Birmingham

2:20-2:40 P. M.

Enzymes in Treatment of Occlusive Vascular Disease, *Anthony P. Fletcher, M. D.*, Associate Professor Medicine, Washington University School of Medicine, St. Louis, Missouri

2:40-3:00 P. M.

The Present Status of Anticoagulant Therapy in Ischemic Heart Disease, *E. E. Eddleman, Jr., M. D.*, Professor of Medicine, Medical College of Alabama; Associate Chief-of-Staff for Research, VA Hospital, Birmingham

3:00-3:20 P. M.

Iatrogenic Occlusive Vascular Disease: A Threat in the Treatment of Congestive Heart Failure, *T. Joseph Reeves, M. D.*, Professor of Medicine, Medical College of Alabama, Birmingham

ADJOURN to Parliament House for Joint panel on "Medical and Surgical Aspects of Occlusive Vascular Disease."

Obstetrical and Gynecological Section

Thursday, April 22, 1965

The Guest House Motor Inn

S. Buford Word, M. D., Presiding

12:30 P. M.

LUNCH—The Guest House Motor Inn (Tickets available at registration desk, Guest House and Parliament House)

Luncheon Program: James Marion Sims Accepted The Challenge, *James P. Marr, M. D.*, Woman's Hospital, New York, New York

2:00 P. M.

Genital Fistulae From Obstetrical Causes, *John C. Hope, Jr., M. D.*, and *O. M. Otts, Jr., M. D.*, Mobile

2:15 P. M.

The Etiology of Genital Tract Fistulae in the Gynecological Patient, *W. N. Jones, M. D.*, Professor, Obstetrics and Gynecology, Medical College of Alabama

2:30 P. M.

The Repair of Genital Tract Fistulae, *David L. Barclay, M. D.*, Assistant Professor, Obstetrics and Gynecology, Tulane University, New Orleans, Louisiana

QUESTIONS AND ANSWERS

3:00 P. M.

COFFEE BREAK

3:30 P. M.

HOW WE PRACTICE

1. Restoration of Function in Treatment of Cyst and Abscess of Bartholin's Gland, *Julian P. Hardy, M. D.*, Birmingham
2. Amenorrhea and Birth Control Pills, *Robert V. Barnett, M. D.*, Birmingham
3. The Actions and Side Reactions of the New Progestins, *Donal E. Barlow, M. D.*, Sylacauga
4. Management of the Adnexal Mass, *John D. Thompson, M. D.*, Professor and Chairman, Department of Gynecology and Obstetrics, Emory University School of Medicine, Atlanta, Georgia

Friday, April 23, 1965

Parliament House

E. B. Glenn, M. D., Presiding

9:00-9:20 A. M.

Injuries of Face and Jaws, *Bruce Holding, M. D.*, Montgomery

9:20-9:40 A. M.

Lessons Learned in the Care of the Patient with Pulmonary Insufficiency, *Leroy D. Vandam, M. D.*, Chief Anesthesiologist, Peter Bent Brigham Hospital, Boston, Massachusetts

9:40-10:00 A. M.

Some Fundamentals of Chest Roentgenology, *Benjamin Felson, M. D.*, Professor and Director of Radiology, University of Cincinnati; Director, Departments of Radiology, Cincinnati General Hospital, Holmes, Drake, Children's and Dunham Hospitals

10:00 A. M.

BREAK

10:15-10:35 A. M.

Alexis Carrell—His Contribution to Tissue Transplantation and Blood Vessel Surgery, *William L. Glenn, M. D.*, Professor of Surgery and Chief of the Cardiovascular Section, Yale University School of Medicine, New Haven, Connecticut

10:35-10:45 A. M.

Alabama's Greatest General Practitioner—J. Marion Sims, *James P. Marr, M. D.*, Woman's Hospital, New York, New York

10:45-11:00 A. M.

Recognition of Fifty Year Club, William Crawford Gorgas Award, Douglas L. Cannon Medical Reporter Award, Recognition of Fraternal Delegates

11:00 A. M.

Jerome Cochran Lecture: Early Diagnosis of Cancer, *W. M. Christopherson, M. D.*, Professor and Chairman, Department of Pathology, University of Louisville School of Medicine, Louisville, Kentucky, introduced by *J. A. Cunningham, M. D.*, Birmingham

12:30 P. M.

LUNCH—The Guest House Motor Inn. (Tickets Available at the Registration Desk, Guest House and Parliament House.)

Surgical Section

Friday, April 23, 1965

Parliament House

F. C. Wilson, Sr., M. D., Presiding

2:00-2:20 P. M.

Mammography in the Study of Breast Diseases, *David M. Witten, M. D.*, Consultant, Section of Diagnostic Roentgenology, Mayo Clinic; Instructor in Radiology, Mayo Graduate School of Medicine, Rochester, Minnesota

2:20-2:40 P. M.

Lobular Carcinoma "in situ" of the Breast, *William H. Hartmann, M. D.*, Surgical Pathologist, Johns Hopkins Hospital; Assistant Professor of Pathology, Johns Hopkins School of Medicine, Baltimore, Maryland

2:40-3:00 P. M.

The Pernicious Pigmented Mole, *William J. Pitts, M. D.*, Clinical Instructor of Surgery, Medical College of Alabama, Birmingham

3:00-3:20 P. M.

Metastases from Primary Cerebral Tumors, *A. Earl Walker, M. D.*, Chairman, Department Neurosurgery, Johns Hopkins Hospital, Baltimore, Maryland

3:20 P. M.

BREAK—View Exhibits

3:30-5:00 P. M.
PANEL

Parliament House

New Concepts in Diagnosis and Treatment of Malignancies—Moderator: *Champ Lyons, M. D.*, Professor and Chairman, Department of Surgery, Medical College of Alabama, Birmingham
Panelists: *William M. Christopherson, M. D., Robert Roth, M. D., Charles M. Huguley, Jr., M. D., William H. Hartmann, M. D., David M. Witten, M. D., William J. Pitts, M. D., A. Earl Walker, M. D., David L. Barclay, M. D.*

Medical Section

Friday, April 23, 1965

Liberty National Building Auditorium

W. B. Frommeyer, Jr., M. D., Presiding

2:00-2:30 P. M.

Some Fundamentals of Chest Roentgenology in Regard to Malignancies, *Benjamin M. Felson, M. D.*, Professor and Director of Radiology, University of Cincinnati; Director, Departments of Radiology, Cincinnati General Hospital, Holmes, Drake, Children's and Dunham Hospitals

2:30-3:00 P. M.

Newer Concepts of Chemotherapy in Leukemia, *Charles M. Huguley, Jr., M. D.*, Associate Professor of Medicine, Emory University School of Medicine, Atlanta, Georgia

ADJOURN to Parliament House for joint panel on "New Concepts in Diagnosis and Treatment of Malignancies"

Obstetrical and Gynecological Section

Friday, April 23, 1965

The Guest House Motor Inn

S. Buford Word, M. D., Presiding

12:30 P. M.

LUNCH—The Guest House Motor Inn. (Tickets Available at the Registration Desk, Guest House and Parliament House.)

Luncheon Program: Obstetrical Emergencies, *David L. Barclay, M. D.*, Tulane University, New Orleans, Louisiana.

2:00 P. M.

Resuscitation of the Newborn, **Otto Charles Phillips, M. D.*, University of Pittsburgh, Pittsburgh, Pennsylvania; McGee Hospital for Women, Pittsburgh, Pennsylvania

2:30 P. M.

Obstetrics and Mental Retardation, *John D. Thompson, M. D.*, Professor and Chairman, Department of Gynecology and Obstetrics, Emory University School of Medicine, Atlanta, Georgia

3:00 P. M.

QUESTIONS AND ANSWERS

3:15 P. M.

ADJOURNMENT to Parliament House for panel on "Malignancies."

*Dr. Otto Charles Phillips is appearing through a grant from Merck, Sharp & Dohme Division of Postgraduate Education and is sponsored by the Committee on Maternal and Child Health, Medical Association of the State of Alabama.

Saturday, April 24, 1965

Parliament House

Business Meeting of the Association sitting as the Board of Health of the State of Alabama

(1) Report of the Board of Censors

(2) Revision of the Rolls
  (a) County Societies
  (b) Counsellors
  (c) Correspondents

(3) Election and Installation of Officers

(4) Presentation of Past President's Plaque

ADJOURNMENT

Other Events

Wednesday, April 21, 1965

Exhibitors Party

Cocktail Party for Exhibitors—Sussex Room—Parliament House Motor Hotel, 4:00 to 5:00 P. M. Physicians are invited.

Alabama Orthopaedic Society

Luncheon, Parliament House, 1:00 P. M., Meeting —2:00 P. M.-5:00 P. M., Cocktails, 6:30 P. M., Windsor Room, Dinner, 7:00 P. M., Cambridge Room.

Alabama Academy of Ophthalmology and Otolaryngology

The Alabama Academy of Ophthalmology and Otolaryngology will have a dinner meeting at 7:00 P. M. in the Sussex Room of the Parliament House.

University of Alabama Alumni

Cocktails—6:00 P. M., Dinner—7:00 P. M., Terrace Ballroom, Tutwiler Hotel. REUNIONS FOR CLASSES OF 1935, 1945, and 1955.

Thursday, April 22, 1965

Luncheon—The Guest House Motor Inn, 12:30 P. M. All physicians are invited. Luncheon Program: "James Marion Sims Accepted the Challenge," James P. Marr, M. D., Woman's Hospital, New York, New York. (Tickets available at registration desk.)

Alabama Academy of Neurology, Psychiatry, and Neurosurgery

The Alabama Academy of Neurology, Psychiatry, and Neurosurgery will convene in the Windsor Room of the Parliament House at 6:00 P. M. for cocktails. Dinner will be served at 7:00 P. M. The meeting at 8:00 P. M. will feature A. Earl Walker, M. D., Chairman, Department of Neurosurgery, Johns Hopkins Hospital, Baltimore, Maryland. Dr. Walker's subject will be "Post-traumatic Epilepsy."

Barbecue

A Barbecue will be held at the Norwood Clinic beginning at 6:00 P. M.

Friday, April 23, 1965

Past Presidents and Fifty Year Club

A breakfast honoring the Past Presidents and members of the Fifty Year Club will be given by the Medical Association in the Windsor Room of the Parliament House at 7:30 A. M.

Alabama Chapter International College of Surgeons

The Alabama Chapter of the International College of Surgeons will have a breakfast business meeting at 7:30 A. M. in the Normandy Room B of the Guest House Motor Inn.

Alabama Radiological Society

The Alabama Radiological Society will meet for lunch at 12:30 P. M. at the Relay House.

Luncheon

The Guest House Motor Inn, 12:30 P. M. All physicians are invited. Luncheon Program: "Obstetrical Emergencies," David L. Barclay, M. D., Tulane University, New Orleans, Louisiana.

Alabama Society of Anesthesiologists

The Alabama Society of Anesthesiologists will entertain at a dinner at "The Club," 6:00 P. M. Speaker will be Leroy D. Vandam, M. D., Chief Anesthesiologist, Peter Bent Brigham Hospital, Boston, Massachusetts.

Vanderbilt University Alumni

The Vanderbilt University Alumni will entertain at a Cocktail Party at 5:30 P. M. in the Windsor Room of the Parliament House Motor Hotel.

Scroll and Key Club

The Scroll and Key Club will entertain at the Vestavia Country Club with Cocktails at 6:00 P. M., Dinner at 7:00 P. M. and a Dance at 9:00 P. M.

PROGRAM

Of The

WOMAN'S AUXILIARY

To The

MEDICAL ASSOCIATION OF THE STATE OF ALABAMA

SHERATON MOTOR HOTEL

APRIL 22, 23, 1965

OFFICERS

President

Mrs. L. H. Clemmons ..... Cullman

President-Elect

Mrs. J. F. Crenshaw ..... Birmingham

Vice-Presidents

Southwest—Mrs. Wm. P. Baston ..... Mobile
Southeast—Mrs. E. F. Campbell ..... Montgomery
Northwest—Mrs. J. P. Brooke ..... Bessemer
Northeast—Mrs. Eugene Bradley ..... Centre

Recording Secretary

Mrs. R. K. Wilson ..... Aliceville

Corresponding Secretary

Mrs. John T. Morris ..... Cullman

Treasurer

Mrs. T. K. Lewis ..... Decatur

Finance Officer

Mrs. H. Price Edwards ..... Birmingham

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Mrs. Jack Yeager ..... Mobile

Parliamentarian

Mrs. William G. Thuss, Sr. ..... Birmingham

Directors

Mrs. W. R. Sutton ..... Blountsville
Mrs. John M. Kimmey ..... Elba
Mrs. E. V. Caldwell ..... Huntsville

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Dr. L. H. Clemmons, Chairman ..... Cullman
Dr. W. G. Thuss, Sr. ..... Birmingham
Dr. G. W. Newburn, Jr. ..... Prichard
Dr. John M. Kimmey ..... Elba
Dr. Ira Patton ..... Oneonta

COMMITTEES

A. *Sponsored by the Woman's Auxiliary to the American Medical Association:*

AMA-ERF—Mrs. William Anderson, Tuscaloosa
Bulletin—Mrs. S. B. Chenault, Decatur
Civil Defense—Mrs. Philip S. Bazar, Montgomery
Community Service—Mrs. John Boggess, Guntersville
Health Careers—Mrs. Earl Wert, Mobile
International Health Activities—Mrs. J. C. Guin, Jr., Tuscaloosa
Legislation—Mrs. James K. V. Willson, Mobile
Members-at-Large—Mrs. Reuben R. Harris, Birmingham
Membership—Mrs. James F. Crenshaw, Birmingham
Mental Health—Mrs. R. A. Dillard, Birmingham
Program—Mrs. E. J. Phillips, Decatur
Rural Health—Mrs. C. L. Salter, Talladega
Safety—Mrs. Harry C. Shirkey, Birmingham
WA-SAMA—Mrs. Felix Henley, Birmingham

B. *Sponsored by Woman's Auxiliary to the Southern Medical Association:*

Southern Projects—Mrs. Gilder Wideman, Birmingham

C. *Sponsored by the Woman's Auxiliary, Medical Association of the State of Alabama:*

Archives and Exhibits—Mrs. J. R. Horn, Bessemer
Essay Contest—Mrs. William Rosser, Birmingham
Memorial—Mrs. William Noble, Fort Payne
Nominating—Mrs. W. R. Sutton, Blountsville

Press and Publicity—Mrs. W. A. Cunningham, Birmingham; Co-Chairman—Mrs. W. L. Smith, Montgomery
Revisions—Mrs. John M. Kimmey, Elba
Report Forms—Mrs. W. R. Sutton, Blountsville
WAMASA NEWS—Editor—Mrs. Forrest Little, Jr., Montgomery
Assistant Editor—Mrs. Harry Till, Montgomery
Typist—Mrs. W. L. Smith, Montgomery
Circulation Manager—Mrs. John M. Pickering, Montgomery
Yearbook—Mrs. J. C. Chambliss, Cullman

D. *Officers and Committee Chairmen Woman's Auxiliary to the American Medical Association:*
Director—Mrs. John M. Chenault, Decatur
Southeast District Mental Health Chairman—Mrs. W. R. Sutton, Blountsville

E. *Officers Woman's Auxiliary to the Southern Medical Association:*
President-Elect—Mrs. William G. Thuss, Sr., Birmingham

F. *Jefferson County Committees for Convention:*
General Chairman—Mrs. Gilder L. Wideman
Co-Chairman—Mrs. Joseph Campbell
Mailing—Mrs. L. Clark Gravlee
Pages—Mrs. M. H. Powell
Exhibits—Mrs. J. R. Horn
Protocol—Mrs. William G. Thuss, Sr.
Publicity—Mrs. William A. Cunningham
Flowers—Mrs. Wilmot S. Littlejohn
Credentials—Mrs. Bluitt Landers
Hospitality—Mrs. Kellie Joseph
Registration—Mrs. George Zenger, Mrs. Lamar Osment
Finance—Mrs. John Kent
Transportation—Mrs. O. Thomas Bolding
Decorations—Mrs. Samuel K. Cohn

PROGRAM

Wednesday, April 21, 1965

2:00-5:00 P. M.—Pre-Convention Registration, Sheraton Motor Hotel Lobby and Parliament House Lobby—Registration Fee $2.00

3:00 P. M.—Pre-Convention Board Meeting, Sheraton Motor Hotel, Hunt Room
Reports of Chairmen
Transfer of Material to new Chairmen

Thursday, April 22, 1965

8:00 A. M.-3:00 P. M.—Registration, Lobby of the Sheraton Motor Hotel and Lobby of the Parliament House—Registration Fee $2.00

8:00 A. M.—Dutch Breakfast, Top of 21, Sheraton Motor Hotel
"A Showing of Original Hats" by Mrs. Theron Vick, Designer
Hostesses: Jefferson-Bessemer Auxiliary

9:00 A. M.—First General Session, Cloud 21, Sheraton Motor Hotel
Call to Order—Mrs. L. H. Clemmons
Invocation—Rev. Don Hubbard, First Presbyterian Church, Cullman, Alabama
Pledge to the Flag
Auxiliary Pledge—Mrs. John T. Morris, Cullman
"I pledge my loyalty and devotion to the Woman's Auxiliary to the American Medical Association. I will support its activities, protect its reputation, and ever sustain its high ideals."
Greetings—Dr. E. B. Glenn, President, The Medical Association of the State of Alabama
Welcome—Mrs. H. Price Edwards, President, Jefferson-Birmingham Auxiliary
Introduction of Guests—Mrs. Clemmons
Convention Rules of Order—Mrs. Wm. G. Thuss, Sr., Parliamentarian
Report of Reading Committee—Mrs. R. K. Wilson
First Report of Credentials Committee—Mrs. Bluitt Landers
Annual Report of Officers:
President—Mrs. L. H. Clemmons
President-Elect—Mrs. James F. Crenshaw
Northeast District—Mrs. Eugene Bradley
Blount—Mrs. C. V. Hendrix
Calhoun—Mrs. Warren G. Sarrell
Cherokee—Mrs. W. J. Campbell
DeKalb—Mrs. William Noble
Etowah—Mrs. Craig Cantrell
Jackson—Mrs. A. C. Collins
Madison—Mrs. B. B. Jordan
Marshall—Mrs. L. F. Corley, Jr.
Talladega—Mrs. James Wright

Southeast District—Mrs. E. F. Campbell
Coffee—Mrs. John M. Kimmey
Covington—Mrs. A. B. Lee
Elmore-Tallapoosa—Mrs. John Bennett
Geneva—Mrs. Robert L. Martin, Jr.
Houston—Mrs. Ben Byrd
Montgomery—Mrs. Frank C. Miles
Pike—Mrs. J. O. Colley, Jr.

Southwest District—Mrs. William P. Baston
Baldwin—Mrs. Hyman Abrahamer
Dallas—Mrs. George B. Nicholson
Mobile—Mrs. Robert L. Brier

11:00—First Report of Nominating Committee—Mrs. W. R. Sutton
Announcements—Mrs. Gilder Wideman
Memorial Service—Mrs. William Noble
Recess

12:00—Busses Load, Entrance, Sheraton Motor Hotel

12:00—A Reception in the Parlour of the Birmingham Country Club, given by Mrs. William E. Lawrence honoring Mrs. E. B. Glenn

1:00 P. M.—Dutch Luncheon honoring Mrs. Jordan Kelling, President, Woman's Auxiliary to the Southern Medical Association, and Past Presi-

dents of the Woman's Auxiliary to the Medical Association of the State of Alabama, Mrs. L. H. Clemmons, presiding

Invocation—Mrs. Gordon Daves

Introduction of Guests—Mrs. Clemmons

Greetings from Southern Medical—Mrs. Jordan Kelling, Waverly, Missouri

Address—Dr. S. Richardson Hill, Dean, Medical College of Alabama

AMA-ERF Awards—Mrs. William Anderson

6:00 P. M.—Barbecue, Norwood Clinic
Favors—Compliments of General Surgical Supply Co., Birmingham and Durr Surgical Supply Co., Birmingham, Montgomery and Huntsville

Door Prizes

Busses Load for return to Sheraton

Friday, April 23, 1965

8:00 A. M.-12:00 Noon—Registration, Lobby Sheraton Motor Hotel and Lobby, Parliament House—Registration Fee $2.00

9:00 A. M.—Second General Session, Cloud 21, Sheraton Motor Hotel
Call to Order—Mrs. L. H. Clemmons
Invocation—Mrs. John Chenault
Introduction of Guests—Mrs. Clemmons
Annual Report of Officers, continued:
Northwest District—Mrs. J. P. Brooke
Colbert—Mrs. John F. Hensleigh
Cullman—Mrs. C. M. Gross
Jefferson-Bessemer—Mrs. J. S. Callahan
Jefferson-Birmingham—Mrs. H. Price Edwards
Lauderdale—Mrs. R. A. Brannon
Lamar—Mrs. Earl Glenn
Limestone—Mrs. John Waddell
Marion—Mrs. George Ricketts
Morgan—Mrs. Charles Peter Beddow
Pickens—Mrs. Emerson W. Blakney
Tuscaloosa—Mrs. Julian Keller
Walker—Mrs. Robert O. Yuckman
Second Report of Credentials Committee—Mrs. Bluitt Landers

9:50 A. M.—New Business
Recommendations from Executive Board—Mrs. Clemmons
Revisions—Mrs. John M. Kimmey
Presentation of Budget—Mrs. H. Price Edwards
Election of 1965-66—Nominating Committee
Election of Delegates to National Convention
Report of Nominating Committee—Mrs. W. R. Sutton
Election of Officers
Installation of Officers—Mrs. William H. Evans, President, Woman's Auxiliary to the American Medical Association, Youngstown, Ohio
Presentation of President's Pin—Mrs. Clemmons
Address by National Representative—Mrs. William H. Evans
Presentation of Gavel—Mrs. Clemmons
Inaugural Address—Mrs. James F. Crenshaw
Introduction of Committee Chairmen for 1965-66 and time and place of Post Convention Board Meeting—Mrs. Crenshaw
Announcements—Mrs. Gilder Wideman
Recess

12:30—Busses Load, Entrance, Sheraton Motor Hotel

1:00 P. M.—Luncheon honoring Mrs. William H. Evans, Vestavia Country Club, Mrs. H. Price Edwards, presiding
Invocation—Mrs. William G. Thuss, Sr.
Introduction of Guests
Address—Dr. Aubrey S. Miree, Child Psychiatrist
Archives and Exhibits Awards—Mrs. J. R. Horn
"Fashions—Old and New." Commentator—Mrs. William A. Cunningham
Models—Members of Jefferson-Bessemer and Jefferson-Birmingham Auxiliaries
Door Prizes
Announcements—Mrs. Crenshaw
Adjournment—Mrs. Clemmons
The Scroll and Key Club will entertain at the Vestavia Country Club
6:00 P. M.—Cocktails
7:00 P. M.—Dinner
9:00 P. M.—Dance

CONVENTION RULES OF ORDER

1. All persons appearing on the program shall be seated in a reserved section at the front of the room.
2. Members of the voting body shall wear badges at all sessions of the convention.
3. When addressing the chair, the member shall rise, give her name and name of her county auxiliary.
4. Unless notified to the contrary, each speaker shall be limited to two minutes and shall not speak more than twice on any question.
5. A timekeeper will notify each speaker when two minutes are up.
6. All motions shall be written, signed and presented to the Recording Secretary.
7. Reports shall be read only by person making the report or her appointed delegate.
8. Visitors are welcome to all sessions of the convention but are requested to register and to sit apart from the voting body.

HOSPITALITY AND EXHIBIT ROOM, SECOND FLOOR, SHERATON MOTOR HOTEL

Hours

Thursday, 9:00 A. M.-4:00 P. M. (Closed for lunch)
Friday, 9:00 A. M.-4:00 P. M. (Closed for lunch)

AMA Testimony On Eldercare Presented To Congressmen

The American Medical Association has urged that Congress approve the Herlong-Curtis Eldercare bill (H. R. 3727) as the best answer to the problem of providing medical care to people over 65 who need help in paying hospital and doctor bills.

In testimony presented at a closed hearing of the House Ways and Means Committee, representatives of the AMA also reaffirmed the Association's opposition to the King-Anderson bill, known as Medicare.

The Herlong-Curtis Eldercare bill, incorporating recommendations of the AMA, was introduced by Rep. A. Sydney Herlong, Jr., (D.-Fla.) and Rep. Thomas B. Curtis (R.-Mo.).

The AMA was represented before the House Committee by Donovan F. Ward, M. D., Dubuque, Iowa, the Association's president; F. J. L. Blasingame, M. D., AMA executive vice president, and Frank Coleman, M. D., Des Moines, Iowa, past chairman of the AMA Council on Legislative Activities.

The bi-partisan Herlong-Curtis bill, entitled the Eldercare Act of 1965, would amend the Kerr-Mills law to authorize broad health insurance coverage for elderly persons. It would authorize federal grants to the states on a matching basis to help persons 65 years of age and older pay costs of the health insurance if they could not afford it otherwise. The bill would provide for utilization of Blue Shield and Blue Cross plans and private health insurance companies.

The cost of such coverage would be borne entirely by government for those elderly individuals whose income falls below limits set by each state. For individuals with incomes between the minimum and a maximum, government would pay a part of the cost on a sliding scale according to income. Individuals with income above the maximum would pay the entire cost, but they would have the benefits of an income tax deduction for such payments, as well as statewide bargaining for non-cancellable health care policies.



Persons under 65 years of age also would be given an income tax deduction for the amount of premiums paid on non-cancellable health insurance policies to become effective upon retirement.

States could administer the program under state health departments if they so chose. The Kerr-Mills program now is administered by state welfare departments.

Both Herlong and Curtis are members of the Ways and Means Committee which made health-care-for-the-elderly legislation its first business of this session.

In a joint statement when they introduced the bill, Herlong and Curtis said:

"Our legislation is designed to provide elderly persons all the medical services they require, in contrast to the limited benefits in the King-Anderson social security tax bill. Under our bill, workers would not be taxed to pay for hospitalization of those who are financially able to pay for it themselves.

"This legislation would not endanger the solvency of the social security fund or permit control of local hospitals by a federal bureaucracy, as the King-Anderson proposal could.

"This bill goes to the real problem: helping those who need help in financing their health care. That problem would still remain after these individuals had used up the lim-

ited benefits of the King-Anderson bill. Why levy a new tax and set up another federal bureaucracy when it will not do the full job?"

Identical bills were introduced by a number of senators and other members of the House, including Rep. Durward G. Hall (R.-Mo.), who also is a member of the AMA House of Delegates.

The AMA representatives pointed out that the Eldercare bill was designed to provide the elderly who need financial assistance with a wide range of hospital and medical benefits—far more than the limited benefits Medicare would provide.

Under the Herlong-Curtis Eldercare bill, the amount of financial assistance given to the elderly would be determined by the amount of help required, the AMA noted.

The Eldercare plan would expand and enlarge on the existing Kerr-Mills law, preserving state control over administration and requiring no new payroll taxes on wage earners, the AMA said.

They pointed out that Medicare benefits would be restricted to limited hospitalization, some nursing home care in some nursing homes, some hospital-connected diagnostic services, and home nursing care.

Dr. Ward told the Ways and Means Committee that the AMA opposes the King-Anderson medicare bill (H. R. 1) because it "would be unpredictably expensive."

"It is unnecessary," he said. "It would represent a dangerous venture by the federal government in the field of health care.

"Enactment of this program would impose an unfair burden on the nation's wage-earners and their employers to finance health care benefits for millions of older Americans who are self-supporting, even wealthy, and do not need government benefits.

"Further, government regulation and control which would be established under this bill is not compatible with good medicine. The availability of medical service to the aged could be contingent upon the availability of tax money and not upon the medical needs of older citizens. With quantity thus restricted, quality would inevitably suffer. . . .

"We are opposed to government undercutting and disrupting the continuing progress of private health insurance and prepayment plans, on which 145,000,000 Americans of all ages today depend for protection from their illness costs.

"We are opposed to offering false promises to the unfortunate who do need help. This bill would provide only a fraction of the care necessary in any serious illness, a fact which many of our aged do not realize. . . .

"From the beginning, our involvement in this issue has been deep and unavoidable. We physicians care for the elderly and know their health needs better than anyone else. . . .

"We have pursued for years the goal of finding a means for filling the broad medical needs of older citizens, who need help in financing their health care, while preserving for all Americans the high standards and high quality of our present health care system.

"Out of these efforts of the nation's physicians—during which they examined and rejected scores of tentative proposals—has come a series of recommendations which has found expression in H. R. 3727.

"I say categorically that this bill could provide more benefits for persons over 65 who need health care and cannot pay for it, and at less cost to taxpayers, than any other measure pending before Congress. . . .

"Utilizing Blue Cross and Blue Shield and health insurance companies as intermediaries, state governments would be authorized to offer the aged a broad spectrum of benefits, including physicians' care, surgical and drug costs, hospital and nursing home charges, diagnostic services, and X-ray and laboratory fees. These are the components which go to make up an individual's total bill for illness.

"H. R. 1 would cover only a small portion of these services. . . . It would not cover doctors' services or surgical charges. It would not cover drugs outside the hospital or nursing home. It would offer only a partial answer to any serious illness."



around the state

Dr. Donovan Ward Featured Speaker At Meeting

The president of the American Medical Association, Dr. Donovan F. Ward of Dubuque, Iowa, will be featured speaker at the March 29 meeting of the Jefferson County Medical Society.

Dr. Ward holds fellowships in the American College of Surgeons and the International College of Surgeons. He is a member of the Professional Education Committee of the Iowa Division of the American Cancer Society and, in 1949, co-authored the Iowa Cancer Manual.

The AMA president has practiced surgery in his native city of Dubuque since 1931 with the exception of four wartime years when he was a Navy surgeon. He was discharged from the Navy with the rank of commander.

This outstanding Iowa surgeon received his M. D. degree from the University of Iowa College of Medicine in 1930 and interned at St. Mary's Hospital in Detroit. He is chief of the surgical section of Dubuque's Finley Hospital, senior surgeon at Mercy Hospital and consulting surgeon for Xavier Hospital.

He has served the AMA as president, president-elect, vice president and as a delegate from Iowa since 1946.

Dr. Ward has long been active in civic affairs in Dubuque and is past president of the Dubuque Lions Club, past exalted ruler and trustee of the Dubuque Elks Lodge, past commander of the Dubuque VFW, past president of the Iowa Navy League, and Advisory Board member for the YMCA and Salvation Army, past president of the Dubuque Shrine Club and a member of the Iowa "I" Club.

He also is a co-organizer and member of the board of directors of the Life Investors of Iowa and a board member for the Investors Life Company of Iowa.

Obstetricians, Gynecologists Honor Four State Doctors

The American College of Obstetricians and Gynecologists has elected four Alabama physicians to its roll of fellows.

Honored were Dr. William H. Brakefield of Birmingham, Dr. Robert J. Henderson of Selma, Dr. Kathleen Wickman of Montgomery and Dr. Gilder L. Wideman of Birmingham.



Dr. William E. Lawrence, newly elected president of the Jefferson County Medical Society, is shown above, left, presenting the past-president's plaque—and the society's gratitude—to retiring president, Dr. Benjamin Carraway.

Allen Named To Post At University Hospitals

Richard G. Allen has been appointed as Assistant Administrator and Director of Continuing Education and Community Services, University of Alabama Hospitals and Clinics in Birmingham, Matthew F. McNulty, Jr., General Director, announced.

Allen comes to Birmingham from Gunter Air Force Base, Montgomery, where he was Director, Education and Training, Medical Service School, United States Air Force. His contribution to the United States Air Force Medical Service Education Program was recently recognized by his being awarded the First Oak Leaf Cluster to the Air Force Commendation Medal.

In connection with the appointment of Allen, McNulty stressed the expanding educational activities of the University of Alabama Hospitals and Clinics in the total Hospital Administration, Health Science and Health Service educational fields on a statewide basis.

Experience in responsible administrative positions in Air Evacuation, small, 30 bed infirmary-hospitals and large, 1000 bed hospitals has given Allen a wide range of training and experience.

Bone Bank Center Established At Houston

The establishment of three Regional Temporal Bone Banks Centers sponsored by The Deafness Research Foundation to coordinate the acquisition and distribution of bequeathed inner ear structures for a nationwide network of 38 Temporal Bone Banks Laboratories for Ear Research has been announced by Mrs. Hobart C. Ramsey, founder and president.

The new centers include a Southern Regional Temporal Bone Banks Center at Baylor University, Houston, Texas, directed by Frederick R. Guilford, M. D., Clinical Professor of Otology at Baylor University.

JEFFCO SOCIETY HONORS LATE DR. ALICE McNEAL

The Jefferson County Medical Society has adopted a resolution commemorative of the death of one of its former members, Dr. Alice McNeal.

The resolution reads:

"Resolved, that in the recent death of Dr. Alice McNeal, this Society has lost a member of eminent professional and academic attainments, who devoted countless time and talents to the service of her fellow man and to the perpetuation of her skills,

"Resolved, that in the community of which she has been an active member for so many years, her skill as a physician, her high qualities as a person and her unselfish and beneficent life won for her the gratitude and admiration of many, the confidence and respect of all who knew her; and whereas we have been privileged to share in the work and life of Dr. Alice McNeal,

"Resolved, that we respectfully tender to her family and friends in their desolation and bereavement our most sincere and earnest sympathy,

"Resolved, that copies of this resolution be sent to the members of her family, and that a copy be spread upon the minutes of the Jefferson County Medical Society, and that a copy be sent to the editor of the Journal of the Medical Association of the State for publication."

Trio Of State Doctors Named Diplomates By Pathology Board

Three Alabama doctors—Dr. Jerry N. Clanton and Dr. John F. Nickerson of Birmingham, and Dr. Edgar C. Fonde of Mobile—have been certified as Diplomates by the American Board of Pathology.

Scenes At Diabetic Conference



It wasn't all business last month when doctors from throughout Alabama gathered at Ann Jordan Lodge near Alexander City for a symposium on diabetes mellitus sponsored by the Alabama Diabetes Association. The doctors and their families are shown at left enjoying delicious food and hospitality which was a highlight of the weekend. But it was back to business eventually and the center photo shows Dr. Buris R. Boshell of Birmingham (right) discussing diabetic problems with Dr. S. J. Selikoff of Montgomery during a break in the program. The photo at right shows Dr. Killough Patrick of Tuscaloosa, president of the association, addressing some of his colleagues who were in attendance.

Diabetes Association Holds Symposium On Mellitus

Doctors from throughout the state attended a symposium on diabetes mellitus sponsored by the Alabama Diabetes Association at Ann Jordan Lodge Feb. 13.

Following the symposium, the board of directors of the association met.

Included on the program were talks by Dr. A. L. Ennis of Fairfield, Dr. John M. McGehee of Mobile, Dr. Buris R. Boshell of Birmingham, Dr. Leon S. Smelo of Birmingham, Dr. James C. Barrett of Mobile and Dr. Robert Kreisberg of Birmingham.

A new medical clinic in Brewton currently is being constructed by Dr. Herman C. Wood. The building, which will be completed in April or May, will house physician and dental offices. Parking for 43 automobiles will be provided.

* * *

Dr. Charles Donald, Birmingham, thoracic surgeon, was speaker at the January meeting of the Walker County Medical Society. Dr. Donald spoke on the latest trends in chest surgery and smoking. The society's Medical Auxiliary also met and heard a talk by Norbert Black of the Radiological Department, Civil Defense.

Four From Alabama Attend Medical Education Meeting

Four Alabama doctors recently attended a meeting of the Council On Medical Education and Representatives of State Medical Societies held at the Balmoral Hotel in Miami Beach.

Attending were Dr. E. B. Glenn of Birmingham, president of the Medical Association of the State of Alabama, Dr. M. Vaun Adams of Mobile, Dr. John M. Chenault of Decatur and Dr. William L. Smith of Montgomery, editor of the Journal of the State Medical Association of Alabama.

The group discussed the attitude of medical students toward the economics of practice, the possibility of another medical school in Mobile and the relationship of scholarships and their influence on producing practitioners for rural areas.

Dr. Henry B. Gwynn outlined problems faced by the medical profession recently in a speech before the Mobile Optimist Club. Dr. Gwynn defended the medical profession's position on medicare and told of the many advances being made in the treatment and cure of disease.

County Society Officers

Bullock County

Dr. S. A. Cohn — President
Union Springs

Dr. H. S. Banton, Jr. — Vice President
Union Springs

Dr. G. E. Fisher — Secretary-Treasurer
Union Springs

Butler County

Dr. E. V. Stabler — President
Greenville

Dr. T. E. Carter — Vice President
Greenville

Dr. J. H. Dunklin — Secretary-Treasurer
Greenville

Chilton County

Dr. Harold Dumas — President
Clanton

Dr. J. H. Johnson — Vice President
Clanton

Dr. Kent Johns — Secretary-Treasurer
Clanton

Clay County

Dr. C. P. Horn — President
Ashland

Dr. W. V. Clark — Vice President
Lineville

Dr. George L. Beale — Secretary-Treasurer
Ashland

Cleburne County

Dr. Richard T. Lowe — President
Heflin

Dr. Frank R. Wood — Vice President
Heflin

Dr. Richard T. Lowe — Secretary-Treasurer
Heflin

Conecuh County

Dr. Cecil E. Price — President
Evergreen

Dr. Allen U. Hollis — Vice President
Evergreen

Dr. David E. Owensby — Secretary-Treasurer
Evergreen

Covington County

Dr. Morgan J. Moore — President
Andalusia

Dr. C. N. Matthews — Vice President
Florala

Dr. C. D. McLeod — Secretary-Treasurer
Andalusia

Dale County

Dr. R. J. McLaughlin — President
Ozark

Dr. N. W. Holman — Vice President
Ozark

Dr. G. R. Smith — Secretary-Treasurer
Ozark

Dallas County

Dr. Walter L. Greene, Jr. — President
Selma

Dr. Jasper Moore — Vice President
Selma

Dr. J. Hartsell Stewart, Jr. — Secretary-Treasurer
Selma

Elmore County

Dr. W. A. Edwards — President
Wetumpka

Dr. H. C. Nickson, Jr. — Vice President
Eclectic

Dr. C. S. Cotlin, Jr. — Secretary-Treasurer
Wetumpka

Escambia County

Dr. J. B. Thomas, Jr. — President
Atmore

Dr. R. H. Rose — Vice President
Flomaton

Dr. E. F. Goldsmith — Secretary-Treasurer
Atmore

Franklin County

Dr. Blondy S. Henry — President
Russellville

Dr. Robert T. L. Long — Vice President
Russellville

Dr. Wayne P. Hyatt — Secretary-Treasurer
Russellville

Greene County

Dr. J. P. Smith — President
Eutaw

Dr. J. J. Bethany, Jr. — Vice President
Eutaw

Dr. W. H. Frederick — Secretary
Eutaw

Dr. Rucker L. Staggers — Treasurer
Eutaw

Lamar County

Dr. Earl Glenn — President
Vernon

Dr. W. C. Box — Vice President
Sulligent

Dr. W. H. Wright — Secretary
Winfield

Dr. W. F. Gaba — Treasurer
Winfield

Pickens County

Dr. Ronald Henderson ..... President
Gordo

Dr. Robert K. Wilson ..... Vice President
Aliceville

Dr. James H. Gentry ..... Secretary-Treasurer
Aliceville

Winston County

Dr. W. K. Wilson ..... President
Haleyville

Dr. Hobson Manasco ..... Vice President
Haleyville

Dr. J. E. Wood ..... Secretary-Treasurer
Haleyville

Dr. J. L. Church, who recently completed a one-year internship at Baptist Memorial Hospital in Memphis, has opened offices in Huntsville for the general practice of medicine. Dr. Church is a graduate of the University of Tennessee College of Medicine.

* * *

Also opening offices in Huntsville was Dr. Thomas H. Arrington who will practice internal medicine. He is a graduate of Harvard Medical School and interned at the University of Mississippi Medical Center.

James Hamilton Tours University Hospitals

Former Hospital Administrator James A. Hamilton, Director and Professor, Graduate Program in Hospital Administration, University of Minnesota, visited Birmingham recently in connection with the Hospital Administration Graduate educational activities at the University of Alabama Hospitals and Clinics.

Matthew F. McNulty, Jr., General Director, University of Alabama Hospitals and Clinics and Professor of Hospital Administration, serves as Preceptor for the Residency Program in Graduate Education of the University of Minnesota.

Franklin K. Parker of Jackson, Tenn., is the present Resident at the University Hospital from the Minnesota Program.

Dr. Ralph O. Underwood of Russellville recently moved into a new clinic. Facilities include private offices, consultation, X-ray, examination and minor surgical rooms.



Dr. Ira Myers, State Health Officer, journeyed to Brewton last month to address that city's Rotary Club and explain the aims and activities of the State Health Department. Dr. Myers is shown above with one of the charts used to dramatize his presentation.



The Southwest District of the Medical Association of Alabama met in Mobile last month with some 160 doctors and legislators from that area in attendance. The photo above shows some of the crowd while Dr. Everett Strandell of Brewton, vice president of the organization, is pictured in the inset.

Hospital Association To Push Legislative Program

The Board of Trustees of the Alabama Hospital Association has approved a legislative program which the association will endeavor to have enacted by the Alabama Legislature when it convenes in its regular session in May.

The Hospital Association will ask the lawmakers for:

1. Exemption of non-profit hospitals from the state sales and use tax.

2. Enactment of a photocopy law to permit the reproduction of hospital records and their certification to a court as true copies, thereby making it unnecessary for a hospital official or employe to appear in court and make the certification in person.

3. Enactment of legislation to enable governmental (tax-supported) hospitals to grant scholarships and/or grants-in-aid to students in health career studies.

4. More realistic appropriations for the State Health Department.

5. An appropriation of $500,000 for each of the next two fiscal years for the Health Department's Hospital Service for the Indigent Program (HSI).

6. Enactment of a law that would permit patients confined to tuberculosis hospitals in their home counties to cast an absentee ballot in Alabama elections. Under the present law, a patient must be outside his home county to be able to vote an absentee ballot.

7. To amend the State Nurse Practice Act to permit the establishment of a two-year associate degree registered nurse training program in the state.

Matthew F. McNulty, Jr., general director, University of Alabama Hospitals and Clinics, has been awarded the Second Honorary Membership by the Hospital Management Systems Society. The award is "bestowed upon persons of national stature who have made outstanding contributions to the advancement of hospital management systems by scientific means."

Convention Calendar

POSTGRADUATE COURSE ON CARDIOLOGY

March 15-19, Auditorium, Grady Memorial Hospital, Atlanta, Ga., sponsored by The American College of Physicians and arranged by Emory University, registration requests and application blanks to Edward C. Rosenow, Jr., M. D., executive director, American College of Physicians, 4200 Pine Street, Philadelphia, Pa., 19104. Course divided into 10 units of four hours each, as follows: Three units to modern physical diagnosis of the cardiovascular system, one unit to modern management of cardiac arrhythmias, two units to coronary disease, one unit to hypertension, one unit to rheumatic heart disease, one unit to congenital heart disease, and one unit to a miscellaneous group of cardiac problems.

AMERICAN COLLEGE OF PHYSICIANS (Golden Anniversary Session)

March 22-26, Conrad Hilton Hotel, Chicago, Ill., information from Edward C. Rosenow, Jr., M. D., 4200 Pine Street, Philadelphia, Pa., 19104. (Technical Exhibit to be held in conjunction with convention.)

NATIONAL CONFERENCE ON RURAL HEALTH

March 26-27, Americana Hotel, Miami Beach, Fla., to discuss means of providing full-range health services for the nation's 60,000,000 rural residents, including implementation of programs for financing hospital and doctor costs among rural residents.

AMERICAN COLLEGE OF PHYSICIANS POST CONVENTION (MEXICAN) TOUR

March 27-April 4—Mexico City, Cuernavaca, Taxco and Acapulco, Mexico, to attend the Mexican Regional Meeting of the American College of Physicians.

JEFFERSON COUNTY MEDICAL SOCIETY

March 29, Birmingham, Dr. Donovan C. Ward, president of the American Medical Association, guest speaker.

MEDICAL COLLEGE OF GEORGIA CONTINUING SYMPOSIUM

March 31-April 2—Augusta, Ga., continuing medical education symposium on gastroenterology.

ORTHOPEDIC SYMPOSIUM

April 2-3, Texas Children's Hospital Auditorium, Houston, Tex., sponsored by the Department of Orthopedic Surgery, St. Luke's Episcopal Hospital and the Baylor University College of Medicine, Drs. Daniel Riordan, Emanuel B. Kaplan and S. Benjamin Fowler, guest lecturers on surgery of the adult hand, and Dr. J. Leonard Goldner speaking on children's hand surgery.

AMERICAN SOCIETY FOR THE STUDY OF STERILITY

April 2-4, Jack Tar Hotel, San Francisco, special presentations include the Ortho Medal, the Squibb Prize Paper and the Ayerst Lecture, to be presented by Dr. A. S. Parkes, Physiological Laboratory, Cambridge, England.

AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

April 4-8, Civic Auditorium, San Francisco, annual clinical meeting, scientific papers, round tables, panel discussions, luncheon conferences, forums on current investigations, motion pictures, closed-circuit color television programs and scientific and industrial exhibits included on the program.

GILL MEMORIAL CONGRESS IN OPHTHALMOLOGY

April 5-8, Gill Memorial Hospital, Roanoke, Va., faculty to include Drs. Irving S. Cooper, Dan M. Gordon, Robert W. Hollenhorst, L. B. Holt, Harvey A. Lincoff, A. D. Ruedemann, Jr., and W. T. Thompson.

NUCLEAR MEDICINE FOR THE INTERNIST

April 5-9, Hurd Hall, Johns Hopkins Hospital, Baltimore, sponsored by the American College of Physicians, course concerned with the application of radioisotope methodology to medical diagnosis.

NEW YORK UNIVERSITY HOWARD FOX MEMORIAL LECTURE

April 6, Alumni Hall, 550 First Ave., New York, lecture to be delivered by Dr. O. Braun-Falco, professor and chairman, department of dermatology, University of Marburg, West Germany, title, "The Pathogenetic Mechanisms of Alopecias."

MEDICAL ASSOCIATION OF THE STATE OF ALABAMA
(Annual Session)

April 22-24, Parliament House, Birmingham (Complete program listed on page 267.)

CONGRESS ON ENVIRONMENTAL HEALTH PROBLEMS

April 26-27, Drake Hotel, Chicago, sponsored by AMA, subjects include the application of medicine to the complex environment in which we live today. (Congress acceptable for 12 accredited hours by the American Academy of General Practice.)

HAHNEMANN MEDICAL COLLEGE AND HOSPITAL
(Postgraduate Education Course)

April 26-29, Sheraton Hotel, Philadelphia, course on Mechanisms and Therapy of Cardiac Arrhythmias, directed by Dr. Leonard S. Dreifus.

AMERICAN ACADEMY OF PEDIATRICS

April 26-29, Americana Hotel, Bal Harbour, Fla., spring meeting of the Pan-American Association.

AMERICAN COLLEGE OF SURGEONS
(Chicago Committee on Trauma)

April 28-May 1, John B. Murphy Memorial Auditorium, Chicago, sponsored by American College of Surgeons featuring eight lectures by Jorg Bohler, renowned orthopaedic surgeon who is professor of accident surgery, University of Vienna, program also to include lectures by American surgeons of renown, registration to Dr. John J. Fahey, 1791 Howard St., Chicago, Ill., 60626.

* * *

Dr. Wheeler Gunnels of Elba recently spoke to the Mothers' Club of Elba on the subject, "The Importance of an Annual Medical Check-Up for Mothers."



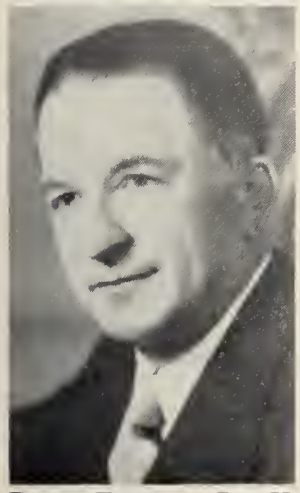
State Senator Pete Mathews, left, and Rep. Rankin Fite—two legislators who will support the Medical Scholarship Bills at the Alabama Legislature—are shown above chatting just before the opening of the special session at Montgomery last month.

In Memoriam

BRUCE F. HOLDING, SR., M. D., F. A. C. S.

Bruce F. Holding, Sr., was born in Wake Forest, North Carolina, July 13, 1893, and he died in Montgomery, Alabama, August 19, 1964.

His premedical education was received at Wake Forest College and the Medical College of Virginia awarded him the M. D. degree in 1917. His specialty training was received at the New York Eye and Ear Infirmary and during World War I he was a Naval Lieutenant, j.g., spending most of the tour of duty in eye, ear, nose and throat work at the U. S. Naval Hospital in Brest, France. Dr. Holding was a life long member of the American Academy of Ophthalmology and Otolaryngology, a Fellow of the American College of Surgeons, a member of the Montgomery County Medical Association, the Medical Association of the State of Alabama, the Southern Medical Association, and the American Medical Association. For many years he served as Chief of the Eye, Ear, Nose and Throat Section of St. Margaret's Hospital and as a member of its Executive Board. He was the Consultant for Eye, Ear, Nose and Throat for the Veterans Hospital in Montgomery.



Each of the thousands of patients that he saw and helped in the 40 years he practiced would immediately realize his sincere interest in their welfare. His gracious manner and sympathetic attitude gave his patients as much inspiration as his science gave them relief. His ready, explosive laugh of friendliness was often heard whenever he attended medical gatherings. The good that he did entitled him to the respect and affection that he found wherever he went. He was faithful to his vocation as a healer of man.

For patients or friends with difficult medical or personal problems, Bruce took the initiative in helping; he did not wait to be called. His memory will ever be green among those who knew him well.

Besides his widow, Mrs. Bruce F. Holding, Sr., three daughters were left: Mrs. John Rollow, Russellville, Arkansas; Mrs. Frances H. Draughon, Birmingham, Alabama; Mrs. Mary H. Jones, Atlanta, Georgia. Almost every doctor wants to leave behind a physician son who can carry on and achieve even more than he could; Bruce, Sr., was fortunate in that he had the gratification of seeing Bruce, Jr., complete a superb training course in otolaryngology, enter the practice of this specialty in his native city, and handle advanced cases which Bruce, Sr., declared were beyond him.

Alston Callahan, M. D.

Pfizer Laboratories Annual Medical Scholarship Announced

The Medical Department of Pfizer Laboratories, Division of Chas. Pfizer & Co., Inc., announced recently that it will make available 88 medical student scholarships for the 1965-1966 academic school year.

The scholarship program provides each of the 88 medical schools in the United States with a $1,000.00 scholarship. These scholarships are administered solely by the dean of each medical school, or by a committee established by him.

Selection of the recipient of the scholarship may be on the basis of scholastic record, financial need, or other criteria determined by the individual medical school. The scholarships are designed primarily to apply toward academic and subsistence expenses of one student in each of the medical schools in the United States.

Alabama Department of Public Health

The State Board of Health has been designated the State Mental Retardation Construction Authority by executive order of Governor George C. Wallace. "Sole power to adopt, administer, and supervise the State Plan for mental retardation" was assigned to "a single State agency," the State Board of Health, so that Alabama might qualify for center construction funds.

This designation of authority by the Governor follows an earlier opinion of the Attorney General that the State Board of Health is the Mental Health Construction Authority under the same laws that make us the Hill-Burton Construction Authority.

In complying with other regulations of the Mental Retardation Facilities Construction Act (Public Law 88-164, Title I), Governor Wallace gave the State Board of Health power to do whatever necessary to meet the requirements of this legislation. He further ordered other State agencies and employees to confer, plan and cooperate with the State Board of Health in meeting these requirements.

The Governor assigned to the State Board of Health the additional duty and power of appointing a State Advisory Council as required by the Mental Retardation Facilities Construction Act. The power to make "reasonable rules and regulations for the administration of the State Plan for mental retardation" is also vested in this body.

Under Title I of Public Law 88-164, $26 million is authorized for the construction of research centers, $32.5 million for the construction of university-associated facilities, and $67.5 million for grants to the States for construction of facilities for the care and treatment of the mentally retarded. In order to receive its share of the construction grants, each State must present a construction program based on a Statewide inventory of existing facilities and survey of need. It must also indicate the priority of projects.

Governor Wallace said, "I do specifically find that the problems of mental retardation are serious problems for the citizens of Alabama. Research is needed in order to solve these problems, and facilities are needed for treatment, care, and education of those people of Alabama that are mentally retarded."

Murfreesboro—Vacancies

STAFF PHYSICIAN for 1275 bed Neuropsychiatric Hospital, including 350 general medical and geriatric. Modern facilities for diagnosis and treatment of mental illness. Salary $12,075 to $21,590 depending on qualifications; fringe benefits; cost of moving to Murfreesboro will be paid by Veterans Administration; visit here for evaluation can be arranged at our expense. Excellent educational opportunities for students in this area. Contact Director, **Veterans Administration** Hospital, Murfreesboro, Tennessee.



AS HEALTH OFFICERS CONFER

County Health Officers from throughout Alabama met in Montgomery last month in a conference presided over by Dr. Ira Myers, State Health Officer. Dr. W. J. Donald, director of county health services, is shown above addressing part of the group. Others in the photo (left to right) are Dr. Myers, Dr. J. Banks Robertson (Fayette, Lamar and Marion), Dr. J. S. Herring (Lauderdale), Dr. J. D. Rayfield (Clay, Shelby and Talladega), Dr. C. D. McLeod (Covington, Geneva, Coffee and Pike), and Dr. E. F. Goldsmith (Baldwin, Conecuh, Escambia and Monroe). Lending an attentive ear in the boxed picture above are Dr. T. N. Page (Bullock, Tallapoosa, Chambers and Barbour), Dr. Cyril F. Floyd (Lee, Macon and Russell) and Dr. C. S. Cotlin, Jr. (Elmore and Coosa).

Other conference views below show, in the left photo, Mrs. Virginia Kendrick, personnel officer for the department, Dr. Otis F. Gay (Madison), Dr. J. G. Baxter (Calhoun, Cleburne, Randolph and St. Clair), Dr. J. C. Chambers (Jefferson), Dr. Virginia Webb (Cherokee and Etowah), and Dr. W. C. Baty, Jr. (Tuscaloosa). At right below are Dr. Webb, Dr. Sidney J. Williams (Greene, Pickens and Sumter), Dr. Baty, Dr. Otto L. Burton (Montgomery), and Drs. Gay, Baxter and Chambers.





BUREAU OF LABORATORIES

Thomas S. Hosty, Ph.D., Director

January 1965

Examinations for intestinal parasites	1,090
Typhoid cultures (blood, feces, urine and other)	263
Examinations for gonococci	1,877
Serologic tests for syphilis (blood and spinal fluid)	23,568
Darkfield examinations	1
Agglutination tests	8
Examinations for diphtheria bacilli and Vincent's	21
Complement fixation tests	79
Examinations for Negri bodies (smears and animal inoculations)	198
Water examinations	2,103
Milk and dairy products examinations	3,753
Examinations for tubercle bacilli	3,641
Miscellaneous examinations	6,143
	42,745

* * *

BUREAU OF PREVENTABLE DISEASES

W. H. Y. Smith, M. D., Director

CURRENT MORBIDITY STATISTICS

1965

	Dec.	Jan.	*E. E. Jan.
Tuberculosis	52	111	109
Syphilis	147	197	115
Gonorrhea	268	349	323
Chancroid	1	3	3
Typhoid fever	1	2	1
Undulant fever	0	0	0
Amebic dysentery	0	2	2
Scarlet fever and strep. throat	297	310	124
Diphtheria	2	0	5
Whooping cough	40	5	7
Meningitis	10	5	8
Tularemia	0	1	2
Tetanus	0	0	2
Poliomyelitis	1	0	0
Encephalitis	0	0	1
Smallpox	0	0	0
Measles	91	358	126
Chickenpox	90	156	155
Mumps	17	24	127
Infectious hepatitis	25	34	35
Typhus fever	0	0	0
Malaria	0	0	0
Cancer	468	479	550
Pellagra	0	0	0
Rheumatic fever	6	25	16
Rheumatic heart	13	27	39
Influenza	39	94	198
Pneumonia	177	277	312
Rabies—Human cases	0	0	0
Pos. animal heads	3	8	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

Acetophenazine Cited In Schizophrenic Study

Following a 24-week psychiatric study of 276 geriatric patients in 13 Veterans Administration Hospitals, acetophenazine "seemed superior in reducing excitement and irritability and inducing improvement in personal neatness," according to an account in the January issue of the Journal of the American Geriatrics Society.

In an article entitled "Behavioral Improvement in the Older Schizophrenic Patient: Drug and Social Therapies," Gilbert Honigfield, Ph. D., and associates from the Central Neuropsychiatric Research Laboratory, V. A. Hospital, Perry Point, Md., reported that three drugs as well as a placebo were used in the study: Acetophenazine, trifluoperazine and imipramine.

The major research questions concerned the effects of the three forms of chemotherapy and of attendance at special group meetings of the patients, who ranged in age from 54 to 74 years. "In terms of reducing the irritability of the patients as seen on the wards by members of the nursing staff," the authors pointed out, "acetophenazine clearly produced the greatest amount of improvement, differing significantly from each of the other drugs in this respect. Consistent with this finding are the data demonstrating that the patients treated with acetophenazine were the only ones who showed an average improvement in personal neatness."

VISITOR

Gordon McLachlan, Secretary of the Nuffield Provencial Hospitals Trust of London, England, visited University of Alabama Hospitals and Clinics recently in connection with part of his six-month sabbatical leave as consultant to the American Hospital Association and the American Hospital Association Research and Education Trust. Mr. McLachlan is in the United States for the purpose of reviewing the health and research here.



The Doctor's Visit, Jan Steen 1626-1679, Mauritshuis, The Hague

In Diverticulosis and Diverticulitis...

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brand of
psyllium hydrophilic mucilloid

"Diverticulosis ...a low-roughage diet is advisable.... Constipation is avoided, preferably by the daily use of Metamucil.

"Diverticulitis Mild, chronic symptoms of diverticulitis, such as diarrhea or flatulence also are treated[1] by low-roughage diet, adequate fluid intake and Metamucil...."

Usual Adult Dosage: One rounded teaspoonful of Metamucil (or one packet of Instant Mix Metamucil) in a glass of cool liquid one to three times daily.

Metamucil is available as Metamucil powder in containers of 4, 8 and 16 ounces and as flavored Instant Mix Metamucil in cartons containing 16 and 30 single-dose packets.

1. Welch, C. E., Diverticula of the Alimentary Tract, in Conn, H. (editor): Current Therapy—1961, Philadelphia, W. B. Saunders Company, 1961, pp. 224-225.

SEARLE

Research in the Service of Medicine

Depend on low-cost, low-dosage Prolixin — once-a-day



Prolixin is a dependable tranquilizer that provides your patient with low cost therapy. No other tranquilizer costs less. Safe and convenient for office use—Prolixin in a single daily dose provides prolonged and sustained action. Markedly low in toxicity and virtually free from usual sedative effects —Prolixin Is indicated for patients who must be alert. Clinical experience indicates fluphenazine hydrochloride is especially effective in controlling the symptoms of anxiety and tension complicating somatic disorders such as premenstrual tension, menopause, or hypertension—also useful for anxiety and tension due to environmental or emotional stress. When you prescribe Prolixin you offer your patient effective tranquilization that is low in cost, low in dosage and low in sedative activity.

THE SQUIBB TRANQUILIZER

WHEN TRANQUILIZATION WITHOUT SEDATION IS DESIRABLE, TRY

PROLIXIN®

SQUIBB FLUPHENAZINE HYDROCHLORIDE

SIDE EFFECTS, PRECAUTIONS, CONTRAINDICATIONS: As used for anxiety and tension, side effects are unlikely. Reversible extrapyramidal reactions may develop occasionally. In higher doses for psychotic disorders, patients may experience excessive drowsiness, visual blurring, dizziness, insomnia (rare), allergic skin reactions, nausea, anorexia, salivation, edema, perspiration, dry mouth, polyuria, hypotension. Jaundice has been exceedingly rare. Photo-sensitivity has not been reported. Blood dyscrasias occur with phenothiazines; routine blood counts are recommended. If symptoms of upper respiratory infection occur, discontinue the drug and institute appropriate treatment. Do not use epinephrine for hypotension which may appear in patients on large doses undergoing surgery. Effects of atropine may be potentiated. Do not use with high doses of hypnotics or in patients with subcortical brain damage. Use cautiously in convulsive disorders.

AVAILABLE: 1 mg. tablets. Bottles of 50 and 500.

For full information, see your Squibb Product Reference or Product Brief.

SQUIBB Squibb Quality—the Priceless Ingredient

SQUIBB DIVISION Olin



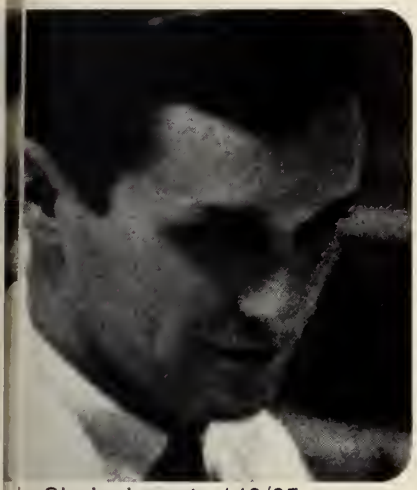
yu a cup of coffee?



Fine! This last patient...



Mrs. Jones?



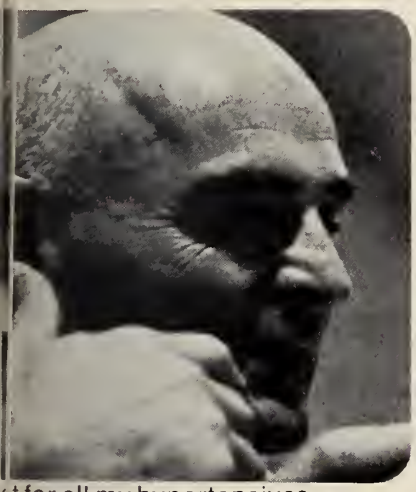
, ir. She's down to 140/85.



Right. When we started, she was 195/120.



Is that Regroton again?



t for all my hypertensives.



Does Regroton always work this well?



Not always. But the exception proves the rule.

sition: Each tablet contains chlorthalidone, and reserpine, 0.25 mg.
indications: History of mental depression, ensitivity, and most cases of severe renal atic diseases.
ıg: Discontinue 2 weeks before general esia, 1 week before electroshock therapy, depression or peptic ulcer occurs.
utions: Reduce dosage of concomitant anti-ensive agents by one-half. Discontinue if JN rises or liver dysfunction is aggravated. olyte imbalance and potassium depletion ccur; take particular care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.
Side Effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.
For full details, see the complete prescribing information.

Availability: Bottles of 100 and 1000 tablets.
Average Dosage: One tablet daily with breakfast.

*Chupkovich, V.; Finnerty, F. A., Jr., and Kakaviatos, N.: The value of chlorthalidone plus reserpine in moderately severe and severe hypertension: A two year study. Presented at the 7th Inter-American Congress of Cardiology, Montreal, June 14–19, 1964.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York
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egroton®

outperformed other antihypertensives in 95% of patients*

Geigy

too young to be so tired...



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Alertonic®

Three tablespoonfuls (45 cc.) contain:		
Pipradrol hydrochloride		2 mg.
Vitamin B_1 (thiamine hydrochloride)	(10 MDR*)	10 mg.
Vitamin B_2 (riboflavin)	(4 MDR*)	5 mg.
Vitamin B_6 (pyridoxine hydrochloride)		1 mg.
Nicotinamide	(5 MDR*)	50 mg.
Choline†		100 mg.
Inositol†		100 mg.
Calcium glycerophosphate	(2% MDR for calcium and phosphorus)	100 mg.
Cobalt (as chloride)		1 mg.
Manganese (as sulfate)		1 mg.
Magnesium (as acetate)		1 mg.
Zinc (as acetate)		1 mg.
Molybdenum (as ammonium molybdate)		1 mg.
Alcohol 15%		

*Multiple of adult Minimum Daily Requirement supplied
†Requirement in human nutrition not yet established

the need for a tonic knows no age

Anyone can feel tired and "old" too soon. In such functional fatigue, Alertonic helps to lift mood, revive interest, restore purposeful activity promptly. Yet it contains no MAO inhibitors, no hormones. Alertonic is the effective formulation of a cerebral stimulant (pipradrol hydrochloride), alcohol, vitamins, and minerals ... available on prescription *only*. For common functional complaints (mild mood depression, tiredness); geriatric or convalescent patients, Rx one *tablespoonful* Alertonic *t.i.d.*, thirty minutes before meals. Contraindicated in agitated pre-psychotic patients, paranoia, or other patients in whom hyperexcitability, anxiety, chorea, or obsessive-compulsive states are present. Mild central stimulant side effects may occasionally occur.

Brochure with full product information available on request.

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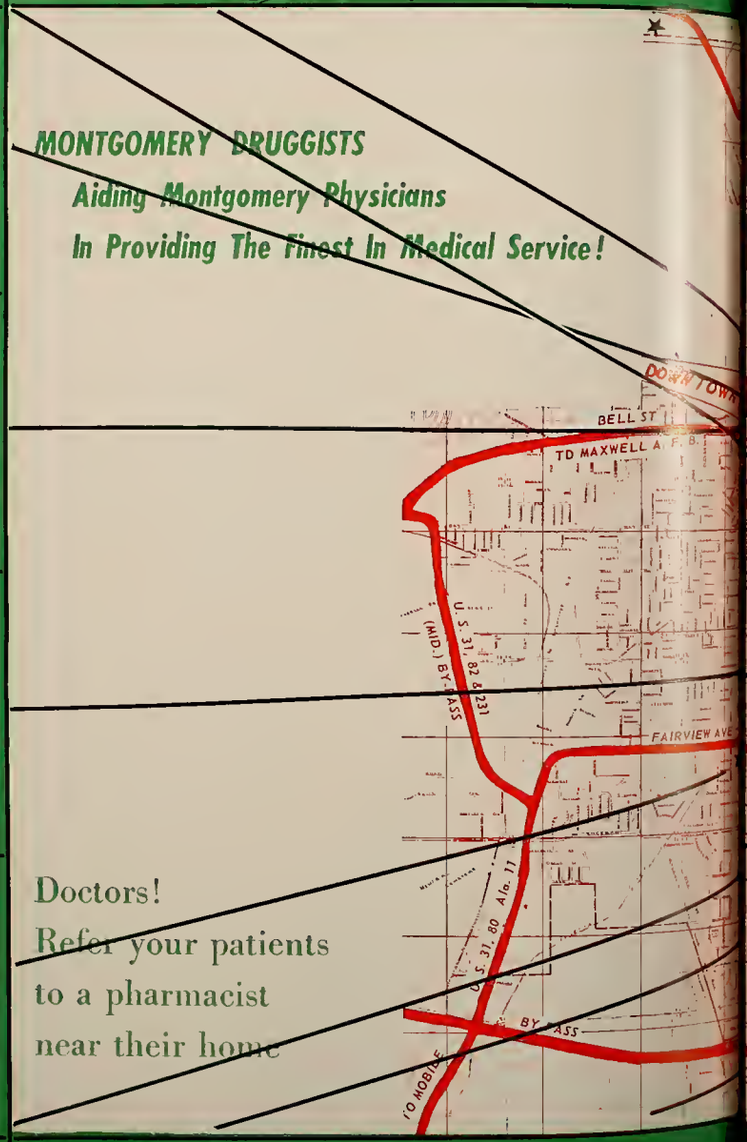


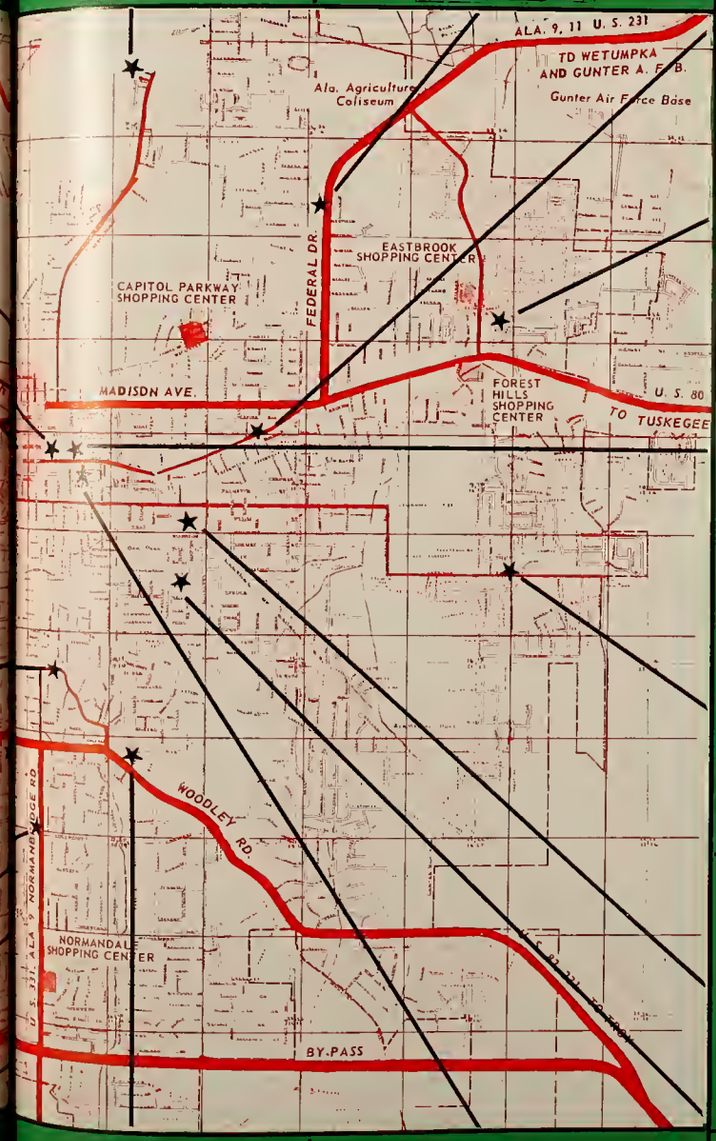
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FOR YOUR ELDERLY ARTHRITIC PATIENTS...

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REASSURING SAFETY FACTORS

Effectiveness, dependability and reassuring Safety Factors make PABALATE-SF a logical choice for antiarthritic therapy in elderly patients—even when osteoporosis, hypertension, edema, peptic ulcer, cardiac damage, latent chronic infection and other common geriatric conditions are present. The potassium salts of PABALATE-SF cannot contribute to sodium retention...the enteric coating assures gastric tolerance...and clinical experience shows that this preparation does not precipitate the serious reactions often associated with corticosteroids or pyrazolone derivatives.

Side Effects: Occasionally, mild salicylism may occur, but it responds readily to adjustment of dosage. Precaution: In the presence of severe renal impairment, care should be taken to avoid accumulation of salicylate and PABA. Contraindicated: An hypersensitivity to any component.

Also available: PABALATE—when sodium salts are permissible. PABALATE-HC—Pabalate-SF with hydrocortisone.

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In each persian-rose enteric-coated tablet: potassium salicylate 0.3 Gm., potassium aminobenzoate 0.3 Gm., ascorbic acid 50.0 mg.

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In anxiety and tension states...

tranquilization
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Trancopal "is effective in symptomatic treatm t of anxiety."* A powerful tranquilaxant, it also l lieves muscle spasm so often accompanying a i- ety and tension. Other indications include: ul r syndrome, spastic colon, alcoholism, prem i- strual tension, and bronchial asthma. Side effe s such as occasional drowsiness, dizziness, flu i- ing, nausea, depression, weakness and drug r h have been observed in less than 3 per cent f patients. If severe, medication should be disc i- tinued. In most patients, side effects are mi r and do not necessitate interruption of treatme t. There are no known contraindications. The us l adult dosage is one Caplet® (200 mg.) three r four times daily; in some patients 100 mg. th e or four times daily suffice. Dosage for child n (5 to 12 years) is usually from 50 to 100 mg. th e or four times daily. Trancopal is available in 2 0 mg. Caplets (green colored, scored) and 100 m g. Caplets (peach colored, scored).

*A.M.A. Council on Drugs: J.A.M.A.183:469 (Feb. 9) 1963.

Tension complicated by pain?

...you want a dependable tranquilaxant plus the analgesic effect of aspirin

Rx

TRANCO-GESIC*

CHLORMEZANONE with ASPIRIN

100 mg. 300 mg.

TRANCO-GESIC...for the more comprehensive control of pain, especially in tension headache, sciatica, lumbago and musculoskeletal pain associated with strains or sprains...acts dependably and with unsurpassed tolerance. Contraindicated in persons known or suspected to have an idiosyncrasy to aspirin. Side effects such as gastric distress, occasional weakness, sedation or dizziness may be noted occasionally. Ordinarily, these may be reversed by a reduction in dosage or temporary withdrawal of the drug. The usual adult dosage is 2 tablets three or four times daily. The suggested dosage for children from 5 to 12 years is 1 tablet three or four times daily. *Trademark

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SANITARIUM
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is a private psychiatric hospital established in 1925 for the treatment of nervous or mental disorders, alcohol or drug addiction problems.

The hospital accepts both men and women. It is departmentalized according to sex and the degree of illness, with different sections for the acutely ill patient, the mildly ill patient, the convalescent patient, and the chronically ill resident patient. All rooms are private.

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Birmingham Regional Hospital Council



for psychiatric treatment

Peachtree Hospital, located in Atlanta, Georgia, is a complete psychiatric, alcoholic and drug addiction treatment facility accredited by the Joint Commission on Accreditation of Hospitals ☐ The hospital has 65 beds, 47 of which are devoted to the care of psychiatric patients and 18 of which, in a separate area, are for patients with acute cases of chronic alcoholism or drug addiction ☐ Treatment procedures include psychotherapy, electroconvulsive shock therapy, subinsulin coma and chemotherapy ☐ *We will be pleased to provide further information upon request.*

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peachtree hospital

41 PEACHTREE PLACE, N. E. TELEPHONE 873-5681 ATLANTA 9, GEORGIA

The Woman's Auxiliary

Dear Doctors:

I'm so full of our new safety campaign that I've just got to tell you about it. Accidents in the home and on the highway are the leading causes of death in age group 1-34 in Alabama. Accidents are killing more Alabama residents in this age group than all diseases combined.

Are there any dangerous situations in your home that may cause someone to die? This check list will help you to see. The Woman's Auxiliary of the Medical Association of the State of Alabama and the Alabama Department of Public Health made up this check list for school children to help make the home a safer place for the family. Want to take the children's test?

ANSWER WITH YES OR NO, OR FILL IN THE BLANKS:

1. Do you have an organized fire evacuation plan for your house? Yes_____ No_____. At least two exits from each bedroom that you could get out of quickly?
2. Is all gasoline and kerosene stored outside your house in a metal container, contents clearly marked, and out of reach of children? Yes_____ No_____.
3. Are children always under the supervision of adults at home? Yes_____ No_____.
4. Are medicines stored only in the medicine chest, never on tables or kitchen shelves? Yes_____ No_____.
5. Are detergents, fly spray, floor wax, and other cleaning items stored in spaces that cannot be reached by children under the age of six? Yes_____ No_____.
6. You should _____ _____ _____ immediately after someone eats detergent, aspirin, or drinks kerosene.
7. Do you have any kerosene stored in soft drink bottles? Yes_____ No_____.
8. You should _____ _____ _____ _____ _____ _____ if your clothing catches on fire.
9. Is there a loaded gun inside your house or any house that you often visit? Yes _____ No_____.
10. Do you keep ammunition stored in a space that cannot be reached by young children? Yes_____ No_____.
11. All fireplaces must have a _____ _____ to prevent someone from falling into the fire.
12. All pot handles must be turned to the _____ side to prevent someone from accidentally knocking the container off or having a younger child pull it off on him.
13. You should ride your bicycle on the _____ side of the street.
14. You must walk on the _____ side of the street.
15. Do you have seat belts in your family car? Yes_____ No_____.
16. If question 15 is yes, are the seat belts fastened every time the car is in motion? Yes_____ No_____.
17. Does your car have good brakes? Yes _____ No_____.
18. Are the windshield wipers working properly? Yes_____ No_____.
19. _____ _____ bed is one of the major causes of burn injuries and fires.
20. _____ mats or nonskid strips should be used in all bath tubs.

* * *

How did you score? This is the questionnaire that is being used in our new safety campaign working with elementary school children. The pilot program is being done in Cullman County. It is going so well, it seems like it is too good to be true. In fact, the superintendent of schools is doing the work for us. The Public Health Department would like for us to make this a statewide campaign. Cullman County's results should be in by the time I write you next. Mr. Alec C. Nations, Coordinator for the Accident Prevention Program of the Alabama Department of Public Health, will be glad to help you prepare such a program for your county.

How did you score? 85 per cent is passing.

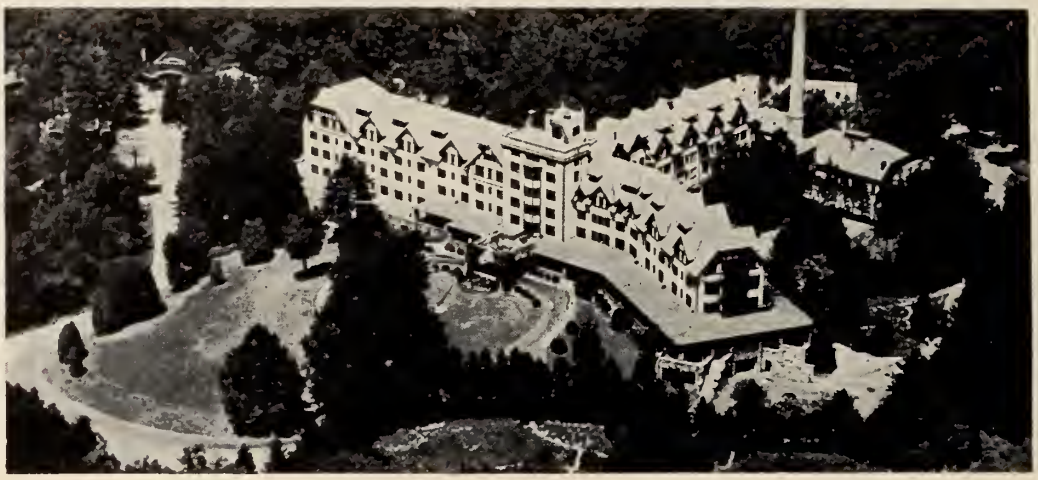
Hope I get a chance to tell you and your wife "howdy" at the convention in April.

Sincerely,
Frances Clemmons

APPALACHIAN HALL

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ASHEVILLE NORTH CAROLINA



An institution for the diagnosis and treatment of psychiatric and neurological illnesses, rest, convalescence, drug and alcohol habituation.

Insulin coma, electroshock and psychotherapy are employed. The institution is equipped with complete laboratory facilities, including electroencephalography and x-ray.

Appalachian Hall is located in Asheville, North Carolina, a resort town, which justly claims an all around climate for health and comfort. There are ample facilities for classification of patients, rooms single or en suite.

Wm. Ray Griffin, Jr., M. D.
Robert A. Griffin, M. D.

Mark A. Griffin, Sr., M. D.
Mark A. Griffin, Jr., M. D.

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A Psychotherapeutic Unit for the Study and Treatment of the Psychoneuroses

Announces
THREE YEAR
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TRAINING
PROGRAM

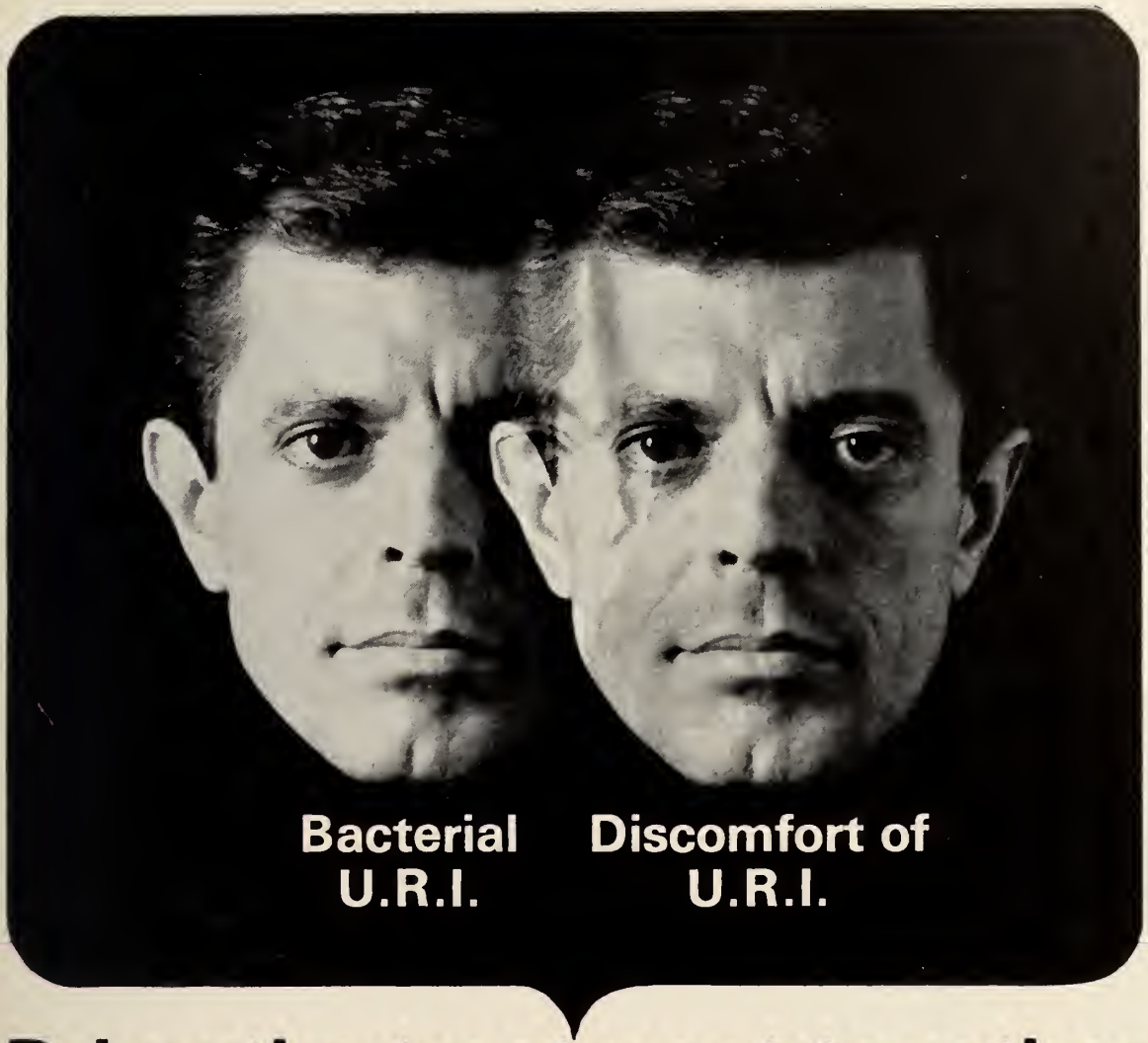
IN PSYCHIATRY

Approved by the American Medical Association and the American Board of Psychiatry and Neurology. Affiliated with Departments of Psychiatry and Neurology of the College of Physicians and Surgeons, Columbia-Presbyterian Medical School, New York City.

First year spent at Medical Center, New York, N. Y., second and third years at Silver Hill, New Canaan, Connecticut. Applicants also considered who have completed one year or more of training elsewhere for the second and third year program.

Emphasis placed on training of physicians for private practice of psychiatry, under experienced preceptors, Board Diplomates, with teaching background. Generous compensation, opportunities for permanent staff appointment. Only outstanding applicants accepted.

For further information and application form, write: William B. Terhune, M. D., Medical Director, The Silver Hill Foundation, Box 1177, New Canaan, Connecticut.



Bring the treatment together in a single prescription

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Tetracycline HCl-Antihistamine-Analgesic Compound

Each tablet contains:			
ACHROMYCIN® Tetracycline HCl	125 mg.	Caffeine	30 mg.
Acetophenetidin (Phenacetin)	120 mg.	Salicylamide	150 mg.
		Chlorothen Citrate	25 mg.

Effective in controlling tetracycline-sensitive bacterial infection and providing symptomatic relief in allergic diseases of the upper respiratory tract. Possible side effects are drowsiness (so one should not drive while on drug), slight gastric distress, overgrowth of nonsusceptible organisms. Tooth discoloration may occur if given during tooth formation (late pregnancy, the neonatal period, early childhood). Reduce dosage in impaired renal function. Increased intracranial pressure is a possible complication in infants. Average adult dosage: 2 tablets four times daily, given at least 1 hour before or 2 hours after meals.

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CHECK

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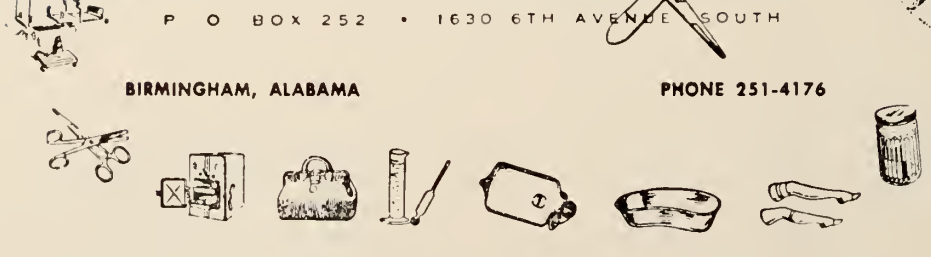


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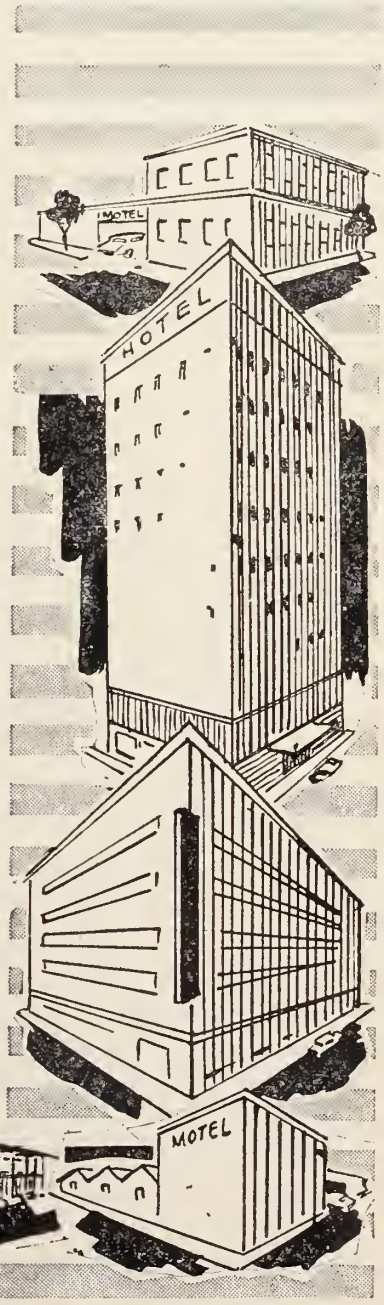
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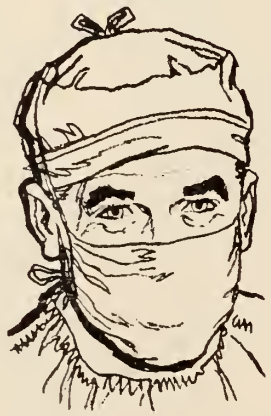
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*Lennox, W. G.: Epilepsy and Related Disorders, Boston, Little, Brown and Company, 1960, vol. 2, p. 865.

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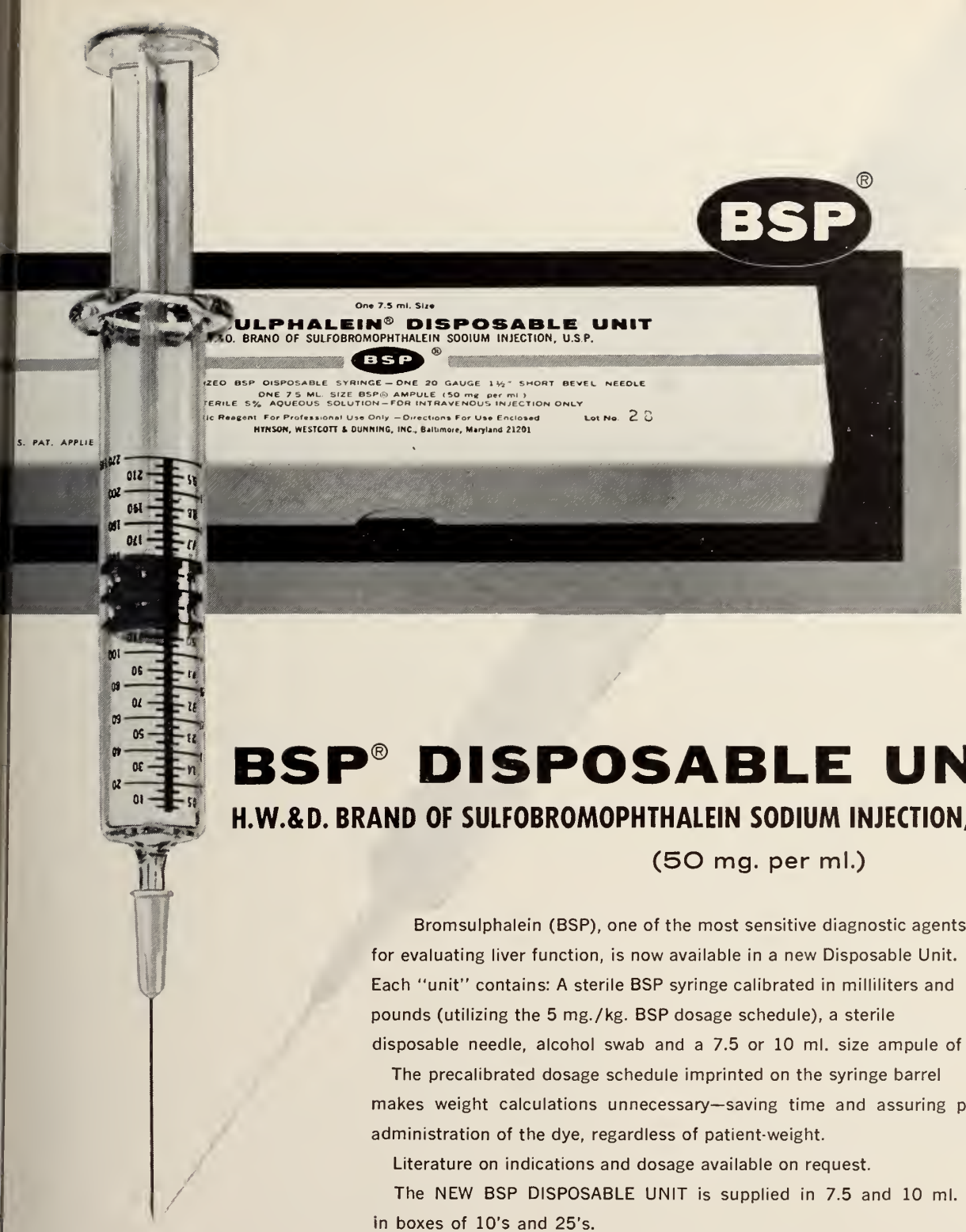
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SIDE EFFECTS: Nausea, GI upset, or mild salicylism may rarely occur. Symptoms of hypercorticoidism dictate reduction of dosage of Arthralgen-PR.

PRECAUTION: Reduction in dosage of Arthralgen-PR given over a long period should be gradual, never abrupt.

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As with any drug containing prednisone, Arthralgen-PR is contraindicated, or should be administered only with care, to patients with peptic ulcer, tuberculosis, nephritis, diabetes mellitus, acute psychoses, Cushing's syndrome (or Cushing's disease), overwhelming spreading (systemic) infection, or predisposition to thrombophlebitis.

Arthralgen-PR is generally contraindicated in patients with uremia and viral infections, including poliomyelitis, vaccinia, ocular herpes simplex, and fungus infections of the eye. It is also contraindicated in patients with chicken pox or susceptible persons exposed to it.

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Contraindications: (1) Hypersensitivity to penicillin. (2) Infections by penicillinase-producing staphylococci and other penicillinase-producing organisms.

Side Effects: Mild effects, such as skin rashes, diarrhea, nausea and vomiting have occasionally appeared.

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References: 1. Editorial. Brit. M. J. *ii*:223 (July 22) 1961. 2. Rolinson, G. N., and Stevens, S.: Brit. M. J. *ii*:191 (July 22) 1961. 3. Stewart, G. T., *et al.:* Brit. M. J. *ii*:200 (July 22) 1961. 4. Brown, D. M., and Acred, P.: Brit. M. J. *ii*:197 (July 22) 1961. 5. Batchelor, F. R., *et al.:* Nature *183*:257, 1959. 6. Knudsen, E. T., *et al.:* Brit. M. J. *ii*:198 (July 22) 1961. 7. Doyle, F. P., *et al.:* Nature *191*:1091 (Sept. 9) 1961. 8. Acred, P., *et al.:* Brit. J. Pharmacol. *18*:356, 1962. 9. Harrison, P. M., and Stewart, G. T.: Brit. J. Pharmacol. *17*:420, 1961. 10. Editorial. Lancet *ii*:723 (Oct. 5) 1963.

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OBITUARIES

DR. HENRY W. CHENEY

Dr. Henry W. Cheney, 95, died Feb. 13 at his home in Florence. Dr. Cheney was a former director of the Lauderdale County Health Department, past secretary of the Lauderdale County Medical Society and a former professor at Northwestern University. Survivors include his widow, Mrs. Elinor Hubbard Cheney; two daughters, Mrs. Kathryn Merriam of Santa Cruz, Calif., and Mrs. Robert Swett of Smoke Rise, N. J.; and two sons, Wilder Hubbard Cheney of Florence and Henry W. Cheney, Jr., of Charlotte, N. C.

* * *

DR. B. F. CAFFEY, SR.

Dr. B. F. Caffey, Sr., 78, died Feb. 15 at his office in Oxford. Dr. Caffey had practiced medicine in the Calhoun County area for more than 50 years and was widely known for his civic activities in the community. He is survived by his widow, Mrs. Pearl Caffey, and by one son, Dr. B. F. Caffey, Jr., of Oxford, with whom he shared his practice for several years.

* * *

DR. B. F. CAFFEY, JR.

Dr. B. F. Caffey, Jr., 46, died March 1 in the doctors' lounge at Anniston Memorial Hospital, exactly two weeks after his father succumbed. A graduate of the University of Alabama School of Medicine, Dr. Caffey had a joint practice with his father for 15 years. Survivors include his widow, Mrs. Margaret T. Caffey, and five daughters.

DR. C. P. HAYES

Dr. C. P. Hayes, Sr., 81, who had practiced medicine in Elba for more than 50 years, died March 9. A native of Longstreet, he was active in civic and church affairs and had many honors bestowed upon him. Survivors include a son, C. P. Hayes, Jr., of Elba, and a sister, Mrs. Nora Clark of Ozark.

* * *

DR. A. C. JACKSON

Dr. Albert C. Jackson, Walker County surgeon, died March 10. He was a native of Notasulga and a graduate of the University of Alabama and Tulane Medical College. Dr. Jackson was a longtime fellow of the American College of Surgeons, a member of the Southeastern Surgical Congress and a Life Counsellor of MASA. He was the founder of the Walker County Hospital which he donated to the city of Jasper in 1956. Survivors include the widow, one son, Albert C. Jackson, Jr., of Jasper, and two daughters, Mrs. James Beech of Jasper and Mrs. James Snipes of Montgomery.

* * *

DR. WILLIAM H. ABERNETHY

Dr. William H. Abernethy of Troy died March 14. Dr. Abernethy had served the Pike County Medical Society for many years as Secretary-Treasurer. Survivors include the widow, and two sons, William H. Abernethy, Jr., of Nashville, Tenn., and Thomas B. Abernethy of Troy.

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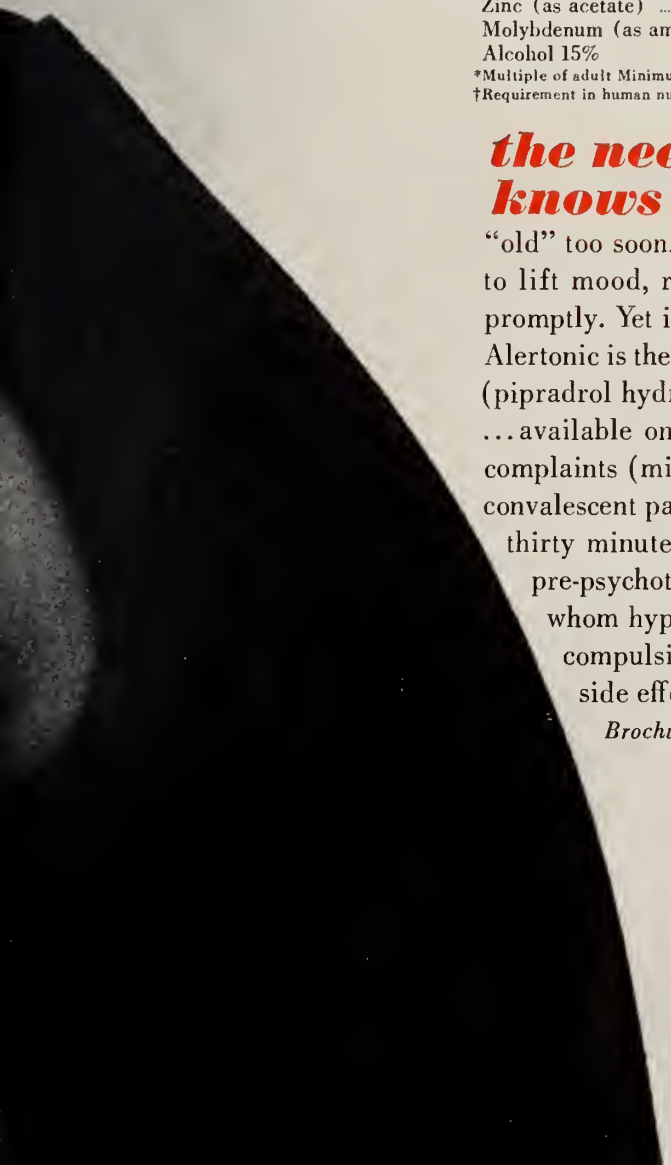


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Side Effects: Glossitis and allergic reactions, as well as severe anaphylactoid reactions, have been reported as rare side effects. Should significant reaction or idiosyncrasy occur, discontinue medication and institute countermeasures. Use of tetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. Reduce usual oral dosage and consider serum level determinations in patients with impaired renal function to prevent possible liver toxicity due to excessive accumulation of antibiotic in the serum.

Precautions: Overgrowth of nonsusceptible organisms may occur. In such cases, discontinue medication and institute appropriate specific therapy as indicated by susceptibility testing. Aluminum hydroxide gel given with antibiotics has been shown to decrease their absorption and is contraindicated. The coloring agents used in Signemycin Syrup and Pediatric Drops may produce red discoloration of stools.

Triacetyloleandomycin, a constituent of Signemycin, administered to adults in daily oral doses of 1.0 Gm. (3 Gm. Signemycin) for periods of more than ten days may produce hepatic dysfunction and jaundice. In the rare patient who requires this high dosage level of Signemycin initially, liver function should be carefully followed and dosage should be reduced, as promptly as possible, to the usual recommended range of 1.0 to 2.0 Gm. per day. Therefore, Signemycin is recommended primarily for the treatment of acute or severe infections, with treatment restricted to a ten-day period. If clinical judgment dictates continuation of therapy beyond ten days, serial monitoring of the liver profile should be carried out, including BSP, transaminase, and cephalin flocculation tests. Changes observed in liver function were reversible following discontinuation of the drug.

Formulas: Capsules: 250 mg. Signemycin (167 mg. tetracycline HCl and 83 mg. oleandomycin as triacetyloleandomycin).

Capsules: 125 mg. Signemycin (83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin).

Syrup: 125 mg. Signemycin (tetracycline equivalent to 83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin) per 5 cc.

Pediatric Drops: 100 mg. Signemycin (tetracycline equivalent to 67 mg. tetracycline HCl and 33 mg. oleandomycin as triacetyloleandomycin) per cc.

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Condition	No. of Patients	No. Responded To Signemycin
Ear, nose and throat infections	507	465
Respiratory infections	1,028	954
Gastrointestinal infections	425	387
Genitourinary infections	748	684
Skin and soft-tissue infections	1,088	1,036
Bone and joint infections	71	64
Deep-seated or generalized infections	257	251
Obstetrical & gynecological infections	341	320
Miscellaneous conditions	592	570
Totals	5,057	4,731 (93.5%)

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1965 Crucial Year For Medicine

By DONOVAN F. WARD, M. D.

President, American Medical Association

The year 1965 is a crucial year for American medicine. It is a year in which important and far-reaching events are transpiring that may have a long-lasting impact on how we practice medicine in America.

An outstanding highlight in medicine in 1965 will be the 114th annual convention of the American Medical Association June 20-24 in New York City. It is our conservative estimate that more than 10 per cent of all American physicians, and perhaps as many as 15 per cent of those in private practice, will register for the New York convention.

Nowhere else in the entire world do physicians gather in such numbers to continue their medical education in an intensive short course that, literally, has something for everyone. Hundreds of scientific papers will be presented by the top medical scientists of our time, from foreign lands as well as our own country. Newest teaching films will be shown. Hundreds of scientists will offer exhibits in which the entire spectrum of medical progress in 1965 will be on view.

American physicians do not attend the AMA annual convention just to take a trip to New York, although that is an interesting sidelight. They attend because they have learned through the years that nowhere else can they find out so much about new developments in medical practice; where they can learn many things that will be of inestimable value to them in their own practices.

The Council on Postgraduate Programs of the AMA has done an outstanding job in preparing the scientific programs for the 114th annual convention. This is the single most important medical scientific meeting in the world this year.

On behalf of your professional society, the American Medical Association, I urge personally that every physician in America attend the June convention.

The 'Future' of Medicare

(From *The Huntsville Times*)

The administration appears to be sure of enough House and Senate votes to enact the Medicare principle—that is medical care financed out of the Social Security System through payroll taxes. And proponents probably will be satisfied with any plan that ties into Social Security.

There now has been a month of executive hearings by the House Ways and Means Committee. There still are a lot of unresolved questions concerning details.

Yesterday the committee began drafting a bill expected to be ready for House floor action about March 22. But one is entitled to



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Therapeutic effects
A number of workers have reported major improvement in 50-75% of cases, with some successful cases going into complete remission.

In responsive cases, improvement is generally seen within a week, so that trial therapy need seldom be continued beyond this period. Alleviation of pain is followed quickly by improvement of function and resolution of effusion or other signs of active inflammation. Relief of arthritic symptoms is quite frequently accompanied by increased appetite, gain in weight and an improved sense of well-being.

The initial response is usually maintained without dosage increases; indeed, initial dosage is often reduced for maintenance purposes.

Salicylate or steroid therapy can usually be diminished or, in some instances, eliminated.

Psoriatic arthritis responds in the same way as rheumatoid arthritis but the skin lesions are usually not affected either favorably or adversely by treatment.

Precautions
Before prescribing, the physician should obtain a complete history and perform a complete physical and laboratory examination, including a blood count.

The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools.

If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time.

Side effects
The most common side effects are nausea, edema and drug rash. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug.

Contraindications
These include: edema, hypertension, or danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when other potent chemotherapeutic agents are given concurrently because of the increased possibility of toxic reactions; when the patient cannot be seen regularly; when the patient is senile.

Note: The physician should be fully aware of dosage, precautions, side effects and contraindications as contained in the complete prescribing information.

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ask why this year's hearings, covering much the same ground as have open hearings in the past, have been surrounded by unusual secrecy.

* * *

We recall a *St. Louis Globe Democrat* story of Feb. 1 which reported that an unpublished government study showed the administration's Medicare proposal would cost $3.8 billion a year by 1975 and that the proposed special health-care fund financed by Social Security taxes would be just about broke by then.

This stirred the temper of some committee members when quoted by Dr. Donovan F. Ward, president of the American Medical Association. But we feel that—regardless of whether there is basic wisdom in the Medicare notion—that the information in the *St. Louis Globe Democrat* story now has been authenticated before a hearing—a closed session—of the Ways and Means Committee.

It is especially relevant, we feel, that the Social Security Administration's top actuary, Robert J. Myers, now has conceded to the House committee that the administration's plan for the elderly ailing cannot be financed on a permanent basis as the measure now shapes up. And Mr. Myers is an authority held in high esteem both by supporters and opponents of Medicare.

He reports that payroll taxes to pay for Medicare will have to be higher or the wage base larger than the $5600 in the bill. Mr. Myers concedes that previously published figures had extended only through 1972 and had not covered 1975. It would be during those three years that the health care fund would apparently undergo drastic deterioration—from a 1972 balance of $1.6 billion to only $258 million at the end of 1975.

Mr. Myers agreed that it would be obvious that the fund would be exhausted at some time after 1972 unless the fund's income were increased through higher payroll taxes.

* * *

It is elementary then (and Mr. Myers would agree with this) that the program can be regarded as on a sound basis only if it is assumed that the wage deduction base be kept up to date by periodic increases.

Now it's true that the administration, the Congress and the public can adopt the obvious current "out"—that they can always decide later how the fund is to be kept out of bankruptcy.

But the full Congress and the public are entitled to go into this program with no blindfold. This isn't the kind of information that they should have to depend on being "leaked" from a committee's closed session.

Health Department Needs Help

(From *The Birmingham Post-Herald*)

Alabama's troubles as far as the State Health Department is concerned are becoming intensified.

Dr. L. R. Murphree, health officer serving Limestone, Morgan and Lawrence counties has just retired on reaching the mandatory retirement age of 70. This leaves the three counties without a health officer.

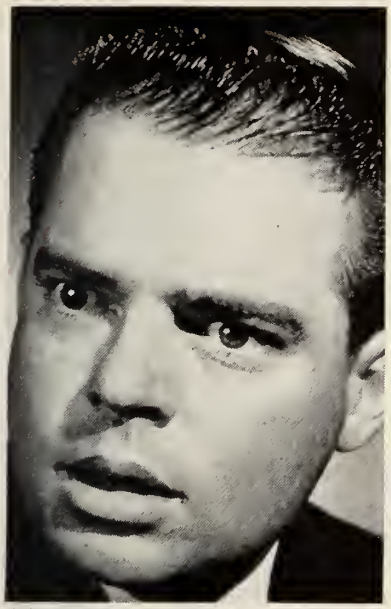
Some nine other counties, including Marshall, Blount and Cullman, have no fulltime health officers.

Warnings were given about this situation some time ago. Alabama's health officers are growing old and few are coming along to replace them.

Money is the chief reason.

Dr. Murphree, on retirement, was drawing the maximum allowed by the state—$12,000 a year, said you can get few doctors to take such a job when they can expect to earn much more in private practice.

Legislators will have this problem before them when they meet in May. They should realize that schools are not the only important thing for Alabama. Money is needed for other branches of government, including the state health department.



F. J. Brown, Jr.—Montgomery-Mobile



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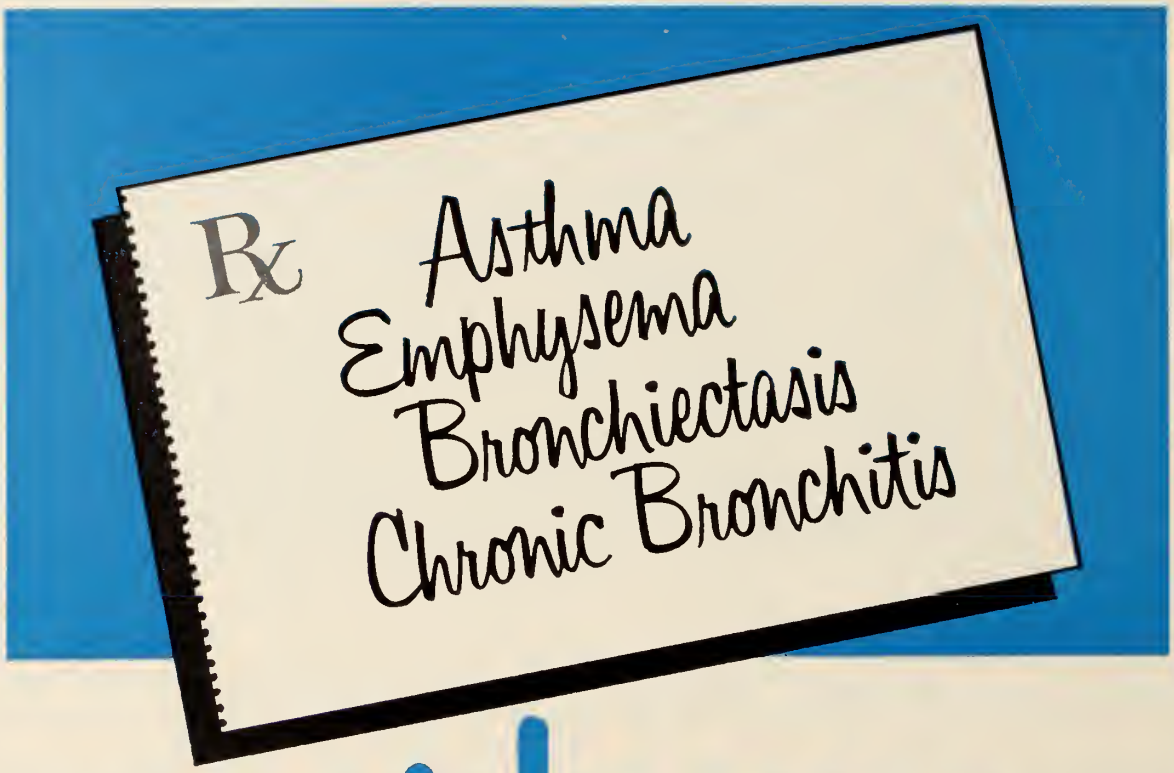
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AMA Supports Vaccination Act Extension

The American Medical Association supports a five-year extension of the Vaccination Assistance Act.

Dr. James Z. Appel, Lancaster, Pa., president-elect of the AMA, and Dr. Robert C. Long, Louisville, Ky., a member of the AMA board of trustees, presented the AMA's position on the vaccination program and three other health care bills at a hearing of the house commerce committee.



"Medicine, on the national, state, county, and community levels, has consistently worked to bring to its patients the benefit of advances in medical research and development," Dr. Appel said. The physicians of America and the Public Health Service have long been partners in the fight against disease and in the campaign to eradicate contagious disease wherever it is found.

"The Vaccination Assistance Act of 1962 was enacted (with AMA support) in recognition of the fact that there existed all over the country pockets of people, particularly children, who were not utilizing, or who did not have available to them, vaccines for the prevention of poliomyelitis, diphtheria, whooping cough, and tetanus. The Act authorizes grants to the states to enable them to engage in a concentrated campaign to provide immunization to people in these pockets. We believe that substantial progress has been made, and we recommended the program's continuation. . . .

"Medical research has since (1962) provided an effective vaccine against measles. An intensive vaccination program directed at preschool age children can dramatically lessen the incidence of the disease and reduce or eliminate the serious residual effects which are sometimes attendant with the disease. We therefore believe that it is most fitting that in extending the Vaccination Act, H. R. 2986 include measles in the authorized vaccination programs."

The AMA also supported a five-year extension of the federal grant program for family health services for migratory workers.

The AMA opposed legislation that would authorize the Public Health Service to construct and operate regional or national research facilities. Dr. Appel said:

"We fail to see how research can be classified as 'regional' or 'national' or 'local'. Research in cancer which may be carried on in a medical school research facility in a midwestern city is as 'national' in character as if it were carried on in a city on the west coast. Research in heart disease, or in any of the many areas of interest to medical science, has no geographic bounds . . .

"We believe that the country will best be served through the utilization of the experience and knowledge of institutions which are currently engaged in medical research. Their record is a good one. We see no reason for beginning a new program which would require many months or years and large sums of money, and which would compete for scarce skilled research manpower. . . . "

Dr. Long outlined the AMA's opposition to use of federal matching funds for initial staffing of community health centers.

"We believe that once the center has been constructed, the community should assume the remaining responsibility," Dr. Long said.

"The providing of medical care is essentially a community affair. The federal government's participation in a matching grant program stimulates the start of the local program and helps the state or community overcome the initial heavy financial burden. Most often, the problem initially facing a community is the one-time large construction-cost expenditure. Assistance here, by way of federal matching grants, is, in our opinion, appropriate. The funds for staffing, however, should remain the sole responsibility of the local community. There does not appear to be any justification for federal participation in financing this type of expense, nor is it likely to phase out, as stated in the bill, once the federal government has assumed this responsibility. If the community cannot, or will not, support the program from its beginning years, it is not likely to do so later."

As for legislation that would authorize federal mortgage insurance and loans to help finance the cost of constructing and equipping facilities for the group practice of medicine and dentistry, the AMA said:

"We do not believe that this proposal for federal subsidy can be justified. Special preference to physicians who will be eligible for the loan or mortgage insurance under this measure can only be supported on the basis that adequate sources of financing do not exist through banks, insurance companies, and other agencies. We know of no such evidence. It has not been demonstrated that this legislation is required to expand currently available public or private funds to finance or insure the construction and equipping of medical or dental groups. . . .

"The bill specifies that the surgeon general shall give preference to, in effect, closed panel prepaid group health plans. This priority discriminates against other physicians in private practice either as solo practitioners or in partnerships or groups."

* * *

The AMA also has emphasized to Congress that the Johnson Administration's plan for a network of regional medical complexes could have "significant impact" upon the practice of medicine in the United States.

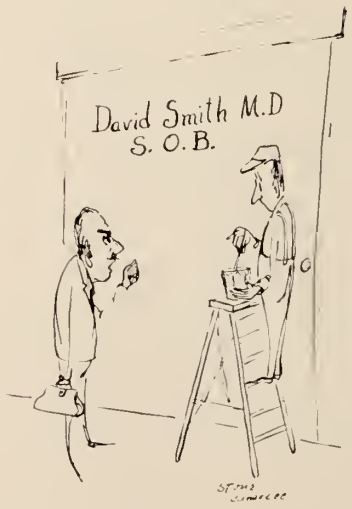
Dr. F. J. L. Blasingame, executive vice president of the AMA, advised Sen. Lister Hill (D., Ala.), chairman of the senate labor and public welfare committee, that the AMA could not testify on short notice on S. 596, the "Heart Disease, Cancer and Stroke Amendments of 1965."

Despite the far-reaching potentialities of the legislation, Hill unexpectedly called two days of hearings on short notice in February.

Blasingame said in a letter to Hill:

"We regret that we found it necessary to inform you that we could not present the Association's views at that time. Because of the short notice given of the hearings, it was not possible to accord this important legislation the proper measure of consideration which it warrants.

"We are sure that this committee must appreciate the tremendous significance of the legislation before it. The purposes of it, namely to assist in combating heart disease, cancer and stroke, and other major diseases, are most laudatory. The eradication or control of such diseases, as well as of all other medical afflictions of man, has been, and continues to be, an active concern and goal of medicine.



"No! No! Spell out Surgery and Obstetrics!"

(The New Physician)

"We deem it imperative that S. 596 be given consideration commensurate with the significant impact which it could have upon the course of medicine and upon the health needs of our citizens.

"The Association has initiated steps within its organization to give to S. 596 a most careful analysis of its intent and the manner in which it is sought to be implemented and achieved. We cannot urge too strongly to this committee that this legislation raises considerations with far-reaching ramifications and with a potential of far-reaching effects upon the nation's health needs. The course to be charted must represent the most judicious employment of the nation's medical resources."

The bill would amend the Public Health Service Act by adding a new title which would authorize the appropriation of $50 million for fiscal 1966, and such sums as may be necessary for the next four years, to be used as grants to assist public or private nonprofit universities, medical schools, research institutions, and other public or nonprofit institutions and agencies in the planning, establishing, and operating of regional medical complexes for research and training and for demonstrations of patient care in the fields of heart disease, cancer, stroke, and other major diseases.

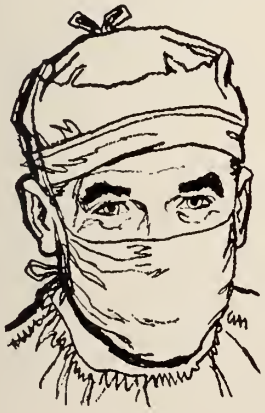
The Administration has refused to give Congress the total amount of planned expenditures on the program, if it is approved by Congress, over the five-year period. But Administration sources estimated $1.2 billion when the legislation was introduced.

* * *

President Johnson has named Dr. Luther L. Terry for another four-year term as surgeon general of the Public Health Service.

A 53-year-old native of Alabama, Terry has been with the PHS since 1942 when he became assistant director of the National Heart Institute. The late President Kennedy appointed him surgeon general in 1960.

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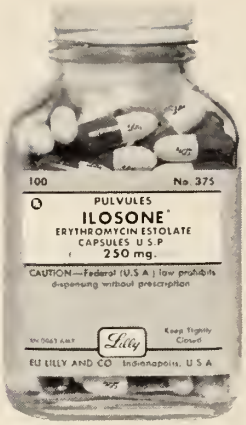
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Fatal Heart Attacks In Male American Physicians In 1954 And 1964

J. H. ROGERS, M. D.
Gadsden, Alabama

During the past ten years a number of measures have been proposed as means of avoiding heart attacks—by all odds the leading cause of death in men. These include fat changes in the diet, obesity control, efforts to lessen emotional and nervous stress and strain, physical exercise, avoidance of cigarette smoking, blood pressure reducers, blood cholesterol reducers, estrogens, thyroid extract, oral diabetic agents, long acting coronary dilators, anticoagulants and no doubt others. In the treatment of the established attack, anticoagulants and drugs for the control of shock have become popular. Furthermore, methods of identifying those prone to heart attacks have been suggested (measurement of serum cholesterol is probably the most common one) in addition to the well recognized ones of heredity, diabetes, high blood pressure, cerebral ischemia, peripheral arterial disease, angina pectoris, and the surest of all, previous nonfatal attacks. It is natural to assume that physicians, being aware of this body of information, would first avail themselves of it. This study therefore is an attempt to compare the current relative incidence of fatal heart attacks in this group with that of ten years ago, and perhaps to achieve some idea of the effectiveness of the suggested preventive measures and treatment. Special mention should be made of widely publicized reports in the early 1950's, indicting cigarette smoking as a cause of lung cancer. These reports undoubtedly promptly led to a marked reduction in cigarette smoking among American physicians. More recently cigarette smoking has been causally "linked" to coronary heart disease.



DR. J. H. ROGERS

Material for the study was obtained from the obituary columns of the *Journal* of the American Medical Association. The cause of death in these notices is usually given and in some detail. The age is always given and the sex may be determined from the name. The great majority are presumably white.

Simple numerical ratios exist among the numbers of the common causes of death and this fact allows meaningful comparisons to be made. Total deaths from all cancer in men remain depressingly constant and therefore cancer deaths have been used as the

MALE AMERICAN PHYSICIANS DEATHS BY CAUSE—1954 AND 1964—
REPRESENTATIVE SAMPLES

	All Cancer	Lung Cancer	Stomach Cancer	Heart Attacks	All Other Heart Disease	Strokes	Non T. B. Infections	T. B.	Accident Homicide Suicide	Pulmonary Emphysema	All Others	Total
TABLE I ALL AGES												
1954	125	14	8	264	138	114	30	4	36	6	91	808
1964	125	17	3	293	160	85	54	2	29	10	89	847
TABLE II UNDER AGE 70												
1954	65	8	3	142	37	41	10	3	22	3	44	367
1964	63	8	1	164	38	18	20	1	22	5	42	373
TABLE III UNDER AGE 70 (ADJUSTED TO 65 TOTAL CANCER CASES)												
1954	65	8	3	142	37	41	10	3	22	3	44	367
1964	65	9	1	178	38	19	22	1	23	5	42	393

yardstick in this study. Cancer of the stomach is said to be declining and special attention attaches to cancer of the lung, particularly since the Surgeon General's report concerning tobacco and health and the unquestionable decline in cigarette smoking in physicians during the past ten years. Therefore, special columns for these malignancies have been kept in the following tables although they are also included in the ALL CANCER Column. While the type of cancer in the obituary notice is usually given, a few are simply reported as "cancer," or the original site of the tumor is not clearly identified. This fact should be borne in mind in considering the numbers of stomach and lung cancer given in the tables. HEART ATTACKS include cases reported as such or as myocardial infarction, coronary thrombosis, coronary disease or other designation which might reasonably be assumed to fall under this general classification.

The 1954 cases were obtained from Volume 156 September—December *Journal* of the American Medical Association. The 1964 cases were obtained from recent issues of the *Journal* beginning in June and working backwards into February. Issues were not necessarily consecutive as some were not available.

There were 125 cancer cases in the 1954 series and this number was used as the yardstick in measuring the 1964 cases. When this number was reached in this year (1964), the recording was stopped; Table I. Table II gives the cases under age 70 (The Biblical allotted time of man) which are extracted from the original table. In this table there are two less cancer cases in the 1964 series as in the 1954 series (63 to 65). This figure is evened out by randomly adding the necessary cases from an additional 1964 issue; Table III.

COMMENT AND CONCLUSION

By the method employed, no improvement in mortality from heart attacks among male American physicians is demonstrated during the past decade (1954-1964)—a period which has seen many proposals for their prevention and treatment. Furthermore, these data are in conflict with the hypothesis that cigarette smoking is causally related to coronary heart disease since there undoubtedly has been a sharp decline in cigarette smoking among physicians during the past ten years. However, a considerable decline in stroke deaths

seems to have occurred, particularly under age 70. In this study no change in lung cancer deaths is noted in the small number of cases recorded.

The dwindling importance of stomach cancer as a major cause of death is documented and is astonishing and unexplained. Some 20 odd years ago gastric carcinoma accounted for about 18 per cent of the total deaths from cancer in the United States and was the commonest form of lethal cancer. (Cecil's Textbook of Medicine, 6th Ed., 1943).

ADDENDUM

Since this paper was submitted for publication, eight issues of The JAMA have appeared in 1965. An abbreviated tabulation from the obituary columns gives the following results which remain in harmony with the COMMENT AND CONCLUSION.

All Cancer	Lung Cancer	Stomach Cancer	Heart Attacks	Strokes
ALL AGES				
78	16	2	201	57
UNDER AGE 70				
40	11	0	122	21

From: The Holy Name of Jesus Hospital, Gadsden, Alabama.

ACKNOWLEDGEMENT

The help of Miss Shannon Rogers, Mrs. Angelyn Brannen, and Sister Stephen Francis, M. S. B. T., B. S. Pharmacy, in compiling this material is gratefully acknowledged.

LETTER TO THE EDITOR

Dear Sir:

Re: Letterhead for each Medical Staff

Does the Medical Staff of any hospital in Alabama have its own letterhead? Do physicians writing on behalf of official medical organizations, particularly those writing at the "grass roots" levels for committees, use a letterhead of that organization, even if typed? I have not known of a "Medical Staff" letterhead in any of the places I've studied and practiced in, including New England, Michigan, New Jersey, Georgia and California.

A particular occasion for a proper letterhead is when "grass roots" workers are writing about business of a medical organization. In many instances, these communications are on hospital letterheads and appear to be coming from an administrator's office, yet the contents of the letters are very foreign to the letterhead.

Today I asked the administrator of a local hospital for his views regarding a "Medical Staff" letterhead. He replied that the trustees of the hospital have their letterhead, he has his letterhead and he felt that it was only right that the Medical Staff have its letterhead. Others with whom I have discussed this topic all feel that this identification would do much to help establish the position of the Medical Staff and help the public understand the position of the physician in relation to organized medicine and organized health services.

Recently I brought this up at the Coweta General Medical Society meeting and we will be initiating a resolution to carry this principle of identification by letterhead through the State and AMA channels, with particular reference and application to Medical Staffs of hospitals. Some Medical Staffs may want to initiate this identification before such a resolution advances through the various channels.

I wonder what the effect would be if government and other planners each received a letter from the Medical Staff of each hospital in Alabama. I do not believe this avenue has been explored.

Sincerely yours,
Robert M. Webster, M. D.

Adenomammectomy For Marked Cystic Disease Of The Breast With Insertion Of Prosthesis

GRAY C. BUCK, M. D., F. A. C. S.

Birmingham, Alabama

Dr. Buck is Assistant Professor of Surgery at the Medical College of Alabama.

Presented at the 13th Annual Scientific Meeting of the Alabama Chapter, American College of Surgeons at the Grand Hotel, Point Clear, Alabama on February 6, 1965.

This is another use for plastic in the human body. It joins the many other spare parts that are now being surgically installed. The title of my paper is "Adenomammectomy for Marked Cystic Disease of the Breast with Insertion of a Prosthesis." Adenomammectomy is the excision of the glandular portion of the breast with preservation of the skin, areola and nipple. This is not a new procedure. Surgeons have been performing this operation for over ten years but their results in the past have not been satisfactory because a good breast prosthesis was not available.

Marked cystic disease of the breast has been a difficult disease process to treat. Hormone therapy, aspiration, and simple biopsy have been the generally accepted conservative methods of treatment. When these have failed, quadrant resection and eventually simple mastectomy have been necessary. Cystic disease of the breast varies from a few simple, isolated cysts (usually in the upper outer quadrant) to generalized shotty breasts to diffuse cystic disease. Nipple discharge is frequent and is usually dirty gray or greenish in color. A bloody discharge from the nipple usually denotes intraductal papilloma or carcinoma and in these cases biopsy is mandatory.

I do not intend to pursue the disease process itself other than to say the exact etiological causes of cystic disease of the breasts are uncertain. Most have been lumped under that category of hormone imbalance.

A patient with advanced cystic disease of the breast soon becomes discouraged with frequent biopsies and unending trips to the doctor's office for evaluation and aspiration. The doctor himself hesitates to resort to the radical but curative therapy of mastectomy. Both the doctor and the patient are very conscious of the possibility of carcinoma. When mastectomy finally became necessary to relieve the patient's plight, an adenomammectomy with an insertion of a breast prosthesis should be considered. If the patient is at all interested, the pitfalls and complications of such a procedure should be carefully explained to her. These are principally:



DR. GRAY C. BUCK

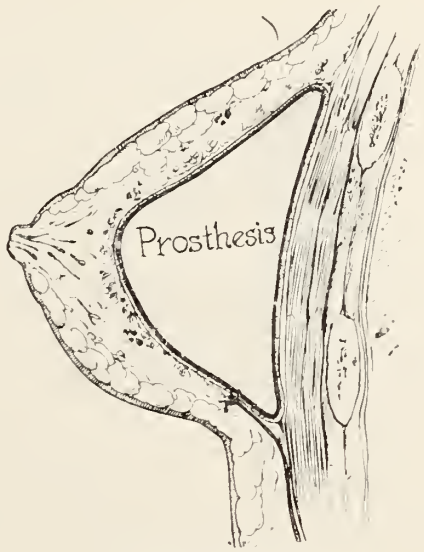
1. Loss of the prosthesis due to infection.
2. Necrosis of the skin or nipple.
3. Final results cannot hope to be exactly like normal breasts.

On the other hand, she can be told that the post-operative appearance and consistency is quite normal and she can be reassured to know that she would be rid of the diseased tissue and that she would never have carcinoma of the breast. Also, if complications should occur, the results would be no worse

than if she had had simple mastectomy initially.

Before presenting the case and the operative technique, I would like to show you the prostheses available and tell you something about them. These prostheses are made of an inert plastic material. The Dow Corning Corporation of Midland, Michigan makes a thin-walled silicone prosthesis which envelops a mass of semifluid silicone gel. This prosthesis is backed with Dacron net to permit tissue fixation and assure firm chest wall attachment. Fibroblasts will not invade this prosthesis. This one is designed to approximate the softness, the contour and the fluid-like mobility of the normal breast. This prosthesis at first impression seems heavy but the specific gravity of the semifluid silicone gel being 0.98 is only slightly greater than that of body fat of 0.90. The second type of prosthesis developed by Dr. John Pangman is made by the Polyplastic Silicone Products Company of Santa Barbara, California. It is made of a premolded inner form of polyurethane, covered by a thin layer of silicone rubber and this in turn covered by a thin sheath of polyurethane. Fibrous tissue penetrates this outer foam covering and allows firm attachment to the fascia and skin but does not invade the silicone layer. Each of these can be ordered in various sizes and shapes to suit the desires and physical characteristics of the patient.

I elected to use the Pangman for replacement after adenomammectomy since it has the porous shell that becomes adherent quickly to the surrounding tissue and is much lighter. Plastic surgeons have also been using



Breast Prosthesis

plastic forms for about ten years to increase the size of the breast. These newer forms have replaced the polyvinyl sponge and the dermafat-fascial transplants. When used for cosmetic purposes, the prosthesis is inserted beneath the breast in a pocket (the retromammary bursa) made between the breast and the pectoralis major muscle through an inferior curved incision. This is a much simpler procedure than performing an adenomammectomy and does not destroy the blood supply or sensation to the breast. The consistency of the breast is not changed appreciably since there is normal breast tissue above the prosthesis.

The patient in this case is a forty-year old, married woman, the mother of an eleven year old child. She was first found to have cystic disease of the breast in 1953 when a biopsy of



Breast Prosthesis Five Months Post Op.

the left breast was done. The pathological report was benign fibrocystic disease of the breast. In 1961 cysts appeared in the right breast and two biopsies were done. The pathological report was again benign cystic disease of the breast. Her doctor continued to follow her for two years and tried hormone therapy and several aspirations. During this time her menstrual cycle remained normal. In 1963 he finally advised mastectomy. There is a familial history of carcinoma in her family. Her mother died of carcinoma of the breast and her aunt of carcinoma of the uterus. I saw this patient for the first time on March 2, 1963, and followed her for 16 months during which time three aspirations of cysts were done. Both of her breasts contained multiple cysts, the largest being on the left and measured about two and one-half centimeters in diameter. The aspirant was a yellow, slightly cloudy fluid. There was no nipple discharge in this case. A mammogram was done and the radiologist reported no areas suspicious of carcinoma but made a diagnosis of diffuse cystic disease of both breasts. Transillumination was of no help.

After discussing the problem with the patient she decided she would like to try the prosthesis. On July 21, 1964, she was taken to the operating room and the skin of the whole anterior chest wall was prepped and draped with vidrape so that we would not have to touch the exposed skin during the dissection. The skin had been prepped the day before with surgical soap. An elliptical incision was made beneath the right breast and with careful dissection the glandular portion of the breast was removed. Special care was taken to make the skin flap as thick as possible and to remove only breast tissue. Bleeding was meticulously controlled with 5-0 black silk. Electrocoagulation and catgut were purposely not used because of possible excessive tissue damage and tissue reaction. While we were drying up the wound as carefully as possible, the specimen was being sectioned at multiple areas for frozen section diagnosis by the pathologist. Until carcinoma was ruled out, dissection on the opposite side could not begin. After clearance from the pathologist, an identical procedure was carried out on the left side. A large Pangman prosthesis was then positioned beneath the skin flaps using the apex of the prosthesis and the nipple and the midline of the clavicle as landmarks. Because of the oozing that occurs following an adenomammectomy, plastic Bardic catheters were placed in each lateral pectoral sulcus and brought out through a stab wound below the incision. These catheters were attached to a Gumco electric suction and were removed 48 hours later. Any accumulation of fluid after this could be aspirated with a needle but in this case aspiration was not necessary. The skin was closed with interrupted 5-0 silk sutures after using 4-0 black silk in the subcutaneous layer. Pressure dressings were not applied because of fear of cutting off the circulation to the skin flaps. A supporting brassiere type of dressing was placed over the incisions and the skin and nipple could be observed for discoloration and ischemia. Prophylactic penicillin and streptomycin were given parenterally. The patient was instructed not to press on the breasts and to lie principally on her back so the prostheses would not slip out of alignment until they had become adherent to the skin and pectoral fascia. The skin sutures were removed in seven days.

This was a one-stage procedure but perhaps a two-stage procedure might be less subject to necrosis and infection—the first stage being a bilateral adenomammectomy, the second the insertion of the prostheses.

In conclusion, insertion of a breast prosthesis should be considered in a patient that needs mastectomy because of marked cystic disease of the breast. This should be used only in selected cases, depending primarily upon the personality and wishes of the patient and finally, this procedure can spare many a woman the severe psychic trauma of the loss of her breasts.

Recent Advances In The Study Of Rheumatoid Arthritis– The Patient On Corticosteroids*

FRANK LEHN, M. D.**

The "steroid era" began in September, 1948, when Dr. Philip Hench administered the first injection of cortisone to a patient with rheumatoid arthritis.[1] In the ensuing years virtually every disease that afflicts man has been given a trial of therapy with corticosteroids or their synthetic analogues. This addition of corticosteroids to the physician's therapeutic armamentarium has brought about the suppression of many disease entities not amenable to other types of therapy.

With the advent of corticosteroid therapy, however, a host of less desirable effects became apparent. These "side effects" included peptic ulcer, osteoporosis, hirsutism, psychotic disorders, hypertension, nitrogen imbalance, diabetes mellitus, abnormal subcutaneous fat deposition, acne vulgaris, skin ecchymoses, increased susceptibility to infection and neurogenic derangement of weight-bearing joints. Other effects that probably result from excessive corticosteroid administration are vasculitis, myopathy and even worsening of the disease process, particularly that of rheumatoid arthritis.

Often, though, the desired effect is sufficiently pronounced so that continued usage is warranted in the majority of patients placed on corticosteroid therapy. Patients with ulcerative colitis, bronchial asthma, connective tissue disease and a host of other disease entities have been satisfactorily managed on long-term corticosteroid therapy.

The patient on long-term corticosteroid therapy presents a special problem to the practicing physician when the patient is subjected to a sudden stress, either foreseen or unforeseen, for acute adrenal insufficiency secondary to pituitary-adrenal suppression may occur in such conditions. Such an emergency was first noted four years after the introduction of corticosteroid therapy. A case of fatal postoperative shock was reported in a patient on maintenance cortisone dosage who had discontinued therapy two days prior to a surgical operation.[2] This first report has been followed by others incriminating both ACTH and corticosteriod therapy as being capable of producing a decreased response to stress by the pituitary-adrenal mechanism. Even while the patient is receiving corticosteroids, the superimposition of a state of stress may lead to acute adrenal insufficiency since the resiliency which characterizes normal pituitary-adrenal function is replaced by a fixed exogenous amount of corticosteroid. Indeed, one may see the picture of Cushing's syndrome in a patient with acute adrenal insufficiency, a paradox of iatrogenic origin.

No general statement can be made with certainty as to which patients will show adrenal atrophy and diminished responsiveness to stress. Two groups[3,4] observed that therapy with hydrocortisone or synthetic analogues for as little as five days would depress adrenocortical function although there was noted to be marked individual variation in that one of the patients studied showed no suppression even after two years of therapy.

Danowski and his group[5] recently published their observations that small doses (20 mgm hydrocortisone or equivalent) of corticosteroids may be administered continuously for years without pituitary-adrenal suppression, large doses (300 mgm hydrocortisone or equivalent) could be administered for a month or more without ill effect and that in-

*This investigation was supported by Public Health Service Grants T1 AM 5000 and AM 03555 from the National Institute of Arthritis and Metabolic Diseases and Merck Sharp and Dohme, West Point, Pennsylvania.

**From the Division of Rheumatic Diseases, Department of Medicine, University of Alabama Medical Center, Birmingham, Alabama.

termittent schedules could be safely utilized for long-term administration of large dosages. These studies were done with relatively healthy subjects and would be difficult to apply to patients with a debilitating disorder such as rheumatoid arthritis in which hypoadrenocorticism or hypopituitarism may be a feature of the disease process itself.

It then becomes incumbent upon the practicing physician to possess a rational scheme for dealing with the exigency posed by the patient on corticosteroid therapy and subjected to stress.

No completely reliable screening test for evaluation of pituitary-adrenal response to stress has been worked out at the time of this writing. The procedures that can be utilized for evaluation rely upon normal physiological mechanisms.

The anterior pituitary secretes ACTH (corticotropin) which in turn stimulates secretion of hydrocortisone and other steroid compounds by the adrenal cortex. Hydrocortisone is the only compound secreted by the adrenal cortex that blocks release of ACTH by the pituitary and thus serves as a "negative feedback" in that the more hydrocortisone present, the less ACTH secreted and vice versa. This action of hydrocortisone may take place at the level of the hypothalamus, for substances liberated here do control ACTH release, it may act at the pituitary level, or at both sites.

The "negative feedback" mechanism can be tested by the use of methopyrapone (SU 4885), a compound that blocks the 11-beta hydroxylation of hydrocortisone precursors. The anterior pituitary, thus released from the inhibiting influence of hydrocortisone, increased the production of ACTH, as measured by a resultant increase in urinary 17-hydroxysteroids.

This test is only a measure of the "negative feedback" control of ACTH secretion. Under conditions of stress, mechanisms other than this are probably responsible for increased ACTH secretion.[6] Reproducible quantitated stresses such as hypoglycemia and bacterial pyrogens have been utilized to evaluate response to stress. Jenkins and Elkington[7] found that the pyrogen test would elicit normal responses (as measured by plasma 17-hydroxycorticosteroid increases) in partially hypophysectomized patients who had shown no response to methopyrapone, indicating that the pyrogen test may be of more significance in evaluating ability to respond to stress in patients with suspected pituitary-adrenal suppression.

Response to ACTH may be even more valuable. Meador[8] has described a characteristic adrenocortical "blunted response" in patients with pituitary-adrenal suppression secondary to long-term corticosteroid therapy. Hydrocortisone secretion by the suppressed adrenal cortex shows prolonged diminution of response to ACTH when graphically plotted.

Sampson[9] has utilized the six-hour plasma hydrocortisone response to intravenous ACTH in a group of patients with ulcerative colitis who had been on prolonged corticosteroid therapy (three weeks or longer in all but one patient) and all had received corticosteroids within a year of operation. Those who responded satisfactorily were not given supplemental corticosteroids and suffered no ill effects when surgery was performed. Those who did not respond satisfactorily did require supplemental corticosteroid therapy. With larger series of patients, this approach may ultimately prove to be the procedure of choice. Its advantages include the relative speed and simplicity of the procedure as well as its possible reliability. Its main disadvantage is that it does not assess pituitary function.

In the emergent situation, of course, no evaluation techniques are available at present.

The lack of adequate facilities and the expense of investigation of each patient individually may be relatively prohibitive. The physician may then decide to give supplemental corticosteroids to the patient that he suspects of pituitary-adrenal suppression but cannot evaluate because of the time required, the expense involved, or the lack of facilities (although relatively modest facilities are re-

EMPIRICAL REGIMEN FOR PATIENTS ON LONG-TERM CORTICOSTEROID THERAPY AT TIME OF OPERATION

SURGERY	MAYO CLINIC[10]	LAHEY CLINIC[10]	UNIVERSITY OF ALABAMA[8,11]
Major Elective	(1) Cortisone Acetate, 200 mgm I.M. 48, 24 and 1 hour before anesthesia. (2) Hydrocortisone Hemisuccinate kept ready for I.V. use if needed. (3) Withdraw abruptly on first or second postoperative day or taper gradually, depending on condition of patient and desirability of treating underlying disease.	(1) Cortisone Acetate, 200 mgm I.M. 12 & 2 hours before anesthesia. (2) Cortisone Acetate, 100 mgm I.M. 12 hours after; 50 mgm at 24 hours and 36 hours; 25 mgm at 48 hours. (3) Hydrocortisone Hemisuccinate kept ready for I.V. use.	(1) 100 mgm Hydrocortisone Hemisuccinate or phosphate I.M. or I.V. q4th on day of operation. (2) 50 mgm q4h. next 24 hours. (3) 50 mgm q6h. next 24 hours. (4) 50 mgm q8h. next 24 hours. (5) 30 mgm q6h. next 24 hours p.o. (6) 20 mgm q6h. next 24 hours p.o. (7) 20 mgm q8h. next 24 hours p.o. (8) 10 mgm q6h. next 24 hours p.o. (9) 10 mgm q8h. next 24 hours p.o.
Major Emergency	(1) Cortisone Acetate, 200 mgm I.M. as soon as possible. (2) Hydrocortisone Phosphate, 100 mgm I.M. 1 hour before anesthesia and every 8 hours thereafter. (3) Hydrocortisone Hemisuccinate kept ready for I.V. use if needed.	(1) Cortisone Acetate, 200 mgm I.M. 2 hours before anesthesia. (2) Hydrocortisone Hemisuccinate, 100 mgm in 500 cc of distilled water I.V. during operation. (3) Postoperative dose as above.	(1) As above.
Minor	(1) Cortisone Acetate, 50 to 100 mgm preoperative 1-2 hours before anesthesia. (2) Cortisone Acetate, 50 mgm when patient recovers consciousness. (3) Hydrocortisone Hemisuccinate kept ready for I.V. use if needed.	(1) Same as Mayo.	(1) 100 mgm Hydrocortisone Hemisuccinate I.M. prior to surgery.

quired for the six-hour intravenous ACTH test).

A prudent approach would seem to be to suspect any patient of pituitary-adrenal suppression who has received 20 mgm of hydrocortisone or equivalent (or unknown dosage) for two weeks or more within the year prior to surgery. This would be particularly applicable in the patient with debilitating disease such as rheumatoid arthritis, myxedema, tuberculosis or others.

In the accompanying table are listed the empirical regimens of the Mayo Clinic, the Lahey Clinic and the University of Alabama Medical Center. These dosage schedules can be amended for any type of stress as well as guidance for "steroid prep" for the surgical patient.

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AMERICAN COLLEGE OF GASTROENTEROLOGY ANNOUNCES ANNUAL RORER AWARDS

The American College of Gastroenterology, in co-operation with William H. Rorer, Inc., of Fort Washington, Pa., has announced the 1965 Rorer Awards Contest for the best papers in Gastroenterology.

There will be two classes of awards. One class is for the best unpublished papers in gastroenterology or an allied subject. This category is open to interns, residents, or fellows. First Prize—$500.00 and a three-year subscription to *The American Journal of Gastroenterology*, official publication of the American College of Gastroenterology; Second Prize—$300.00 and a two-year subscription; Third Prize—$200.00 and a one-year subscription.

All papers submitted must represent original work in gastroenterology, or an allied subject, and must not have been previously presented at meetings of any National Society.

The contents of the papers may be clinical or basic science. Clinical papers must not be case records, but controlled clinical work.

The length of a paper is no criterion for originality or value.

All entries must be typewritten in English, double-spaced on one side of the paper, and submitted in six copies.

The winning entry will be selected by the Research and Scientific Investigation Committee of the American College of Gastroenterology and the awards will be made at the Annual Convention Banquet of the College, to be held in Bal Harbour, Florida in October 1965.

All papers selected for awards become the property of the American College of Gastroenterology, and the decision of the judges will be final.

Should none of the papers submitted meet the standards set by the Committee, the Committee reserves the right to withhold the making of any award.

The recipients of the first two prizes will be given the opportunity of presenting their papers in person at the Annual Meeting of the College in October of 1965.

All entries must be received no later than June 30, 1965 and should be addressed to the Research and Scientific Investigation Committee, American College of Gastroenterology, 33 West 60th Street, New York, N. Y. 10023.

A second award will be given for the best paper published in the American Journal of Gastroenterology. First Prize—$500.00 and a three-year subscription to *The American Journal of Gastroenterology;* Second Prize—$300.00 and a two-year subscription; Third Prize—$200.00 and a one-year subscription.

These prizes are to be awarded for the best papers published in *The American Journal of Gastroenterology* during the 12 months ending June 30, 1965, for which no previous prize has been awarded.

Senate Passes Health Bill

The U. S. Senate has passed the Community Health Services Extension Bill which extends federal grants-in-aid to states to help provide essential health services. The bill was authored by Senator Lister Hill (D-Ala.).

The proposal extends four existing grant-in-aid programs presently authorized under the Public Health Service Act, including the immunization programs against polio, diphtheria, whooping cough and tetanus; programs of matching grants in the fields of mental health, dental health, radiological health, chronic illness and general assistance to State Health Departments; programs of health services for migratory workers and their families; and grants to the twelve schools of Public Health throughout the country.

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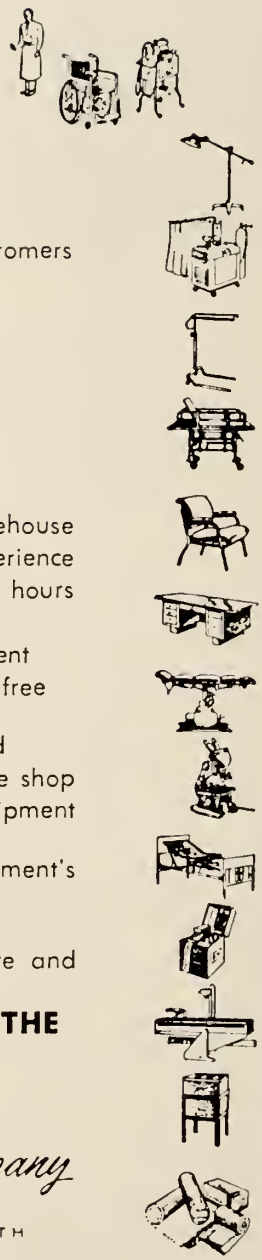
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1965 Annual Session Shapes Up As Great!

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That's the preview of the 104th annual session of the Medical Association of the State of Alabama to be held in Birmingham's Parliament House April 22-24, 1965.

For the ladies, there's the Woman's Auxiliary annual meeting, set for the Sheraton (Colony) Motor Hotel, April 22-23. Both programs are full of interesting speakers and events.

More than 4,000 doctors and their wives are expected for the three-day session which also will attract various social events and class reunions.

All business sessions will be held at the Parliament House, while scientific sessions will be held at the Guest House Motor Inn and the Liberty National Building Auditorium as well as the Parliament House.

Registration desks will be set up at all three locations. Counsellors and delegates, however, must register at the Parliament House.

It is requested that you register immediately upon arrival and pick up your official badge and program. No one will be admitted to exhibit rooms and meeting halls without official badges.

Pre-convention activities begin Wednesday, April 21. Scheduled are meetings of the Alabama Orthopaedic Society, the Alabama Academy of Ophthalmology and Otolaryngology, and the University of Alabama Alumni. A cocktail party for exhibitors also is set for Wednesday.

The official program begins Thursday at 9 a.m. and includes welcoming addresses by Birmingham Mayor Albert Boutwell and Dr. William E. Lawrence, president of the Jefferson County Medical Society.

These will be followed by an orientation program with Dr. James G. Donald, president-elect, presiding. Reports will be made by Dr. J. O. Morgan, Sr., of Gadsden, on the Organizational Structure of MASA; by Drs. S. J. Campbell of Birmingham and E. L. Strandell of Brewton on county medical society organizations and activities; by Dr. J. O. Finney of Gadsden on activities of the State Board of Censors, and by Dr. Ira L. Myers, State Health Officer, on activities of the State Board of Health and County Health Department activities.

Following a break to inspect exhibits, the program continues with reports by Dr. Arthur I. Chenoweth of Birmingham (Ethical Problems), Mr. William Mandy of Birmingham (Blue Cross-Blue Shield), Dr. J. J. Kirschenfeld of Montgomery (The Kerr-Mills Program in Alabama), Dr. Harold Klinger of Montgomery (Maternal and Child Health), Mrs. L. H. Clemmons of Cullman (Woman's



DR. E. B. GLENN



DR. W. STERLING EDWARDS

Auxiliary), Dr. R. K. Oliver of Tuscaloosa (Smoking and Health), Dr. S. Richardson Hill, Jr., of Birmingham (Medical College of Alabama) and Dr. Donald E. Wood of Indianapolis (AMPAC).

The Thursday morning session will conclude with the President's Message by Dr. E. B. Glenn of Birmingham, the outgoing president.

Thursday afternoon's program is divided into three sections—Surgical, Medical, and Obstetrical and Gynecological.





DR. FRANK C. WILSON, JR.



DR. GERHARD F. FUEGER

The Surgical Session, to be held at the Parliament House, will be presided over by Dr. S. J. Campbell. Papers will be read by Dr. W. Sterling Edwards, III, professor of surgery, at the Medical College of Alabama (Thrombophlebitis and Its Sequelae), by Dr. Gerhard F. Fueger of Johns Hopkins' Division of Nuclear Medicine (The Diagnosis of Pulmonary Embolism by Radioisotope Scanning), by Dr. Frank C. Wilson, Jr., of Birmingham (Plication of the Vena Cava) and by Dr. William L. Glenn, professor of surgery and chief of the Cardiovascular Section, Yale University School of Medicine.

The Medical Section will be held at the Liberty National Building Auditorium with Dr. W. B. Frommeyer, Jr., presiding.

Speakers will include Dr. Jon V. Straumfjord, Jr., director of clinical laboratories and Schools of Laboratory Sciences at Hillman Clinic and University Hospital (Diagnostic



DR. WILLIAM L. GLENN



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DR. ANTHONY P. FLETCHER



DR. E. E. EDDLEMAN, JR.

Utility of Lactic Dehydrogenase (LDH) Isoenzymes for Myocardial Infarctions), by Dr. Anthony P. Fletcher, associate professor of medicine at the Washington University School of Medicine, St. Louis (Enzymes in Treatment of Occlusive Vascular Disease), by Dr. E. E. Eddleman, Jr., professor of medicine at the Medical College of Alabama and associate chief of staff for research at the Birmingham VA Hospital (The Present Status of Anticoagulant Therapy in Ischemic Heart Disease) and by Dr. T. Joseph Reeves, professor of medicine at the Medical College of Alabama (Iatrogenic Occlusive Vascular Disease: A Threat in the Treatment of Congestive Heart Failure).

At 3:30 p.m. Thursday, the Surgical and Medical Sections will hold a joint panel discussion at the Parliament House on Medical and Surgical Aspects of Occlusive Vascular Disease, moderated by Dr. Reeves. Panelists will include Drs. Glenn, Straumfjord, Fueger, Wilson, Edwards, Eddleman and Fletcher.



DR. T. JOSEPH REEVES



DR. JAMES P. MARR

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DR. DONAL E. BARLOW

Doctors attending the Obstetrical and Gynecological Section will convene at the Guest House Motor Inn Thursday afternoon for lunch at 12:30 p.m. at which time Dr. James P. Marr of New York's Woman's Hospital will speak on the subject, "James Marion Sims Accepted the Challenge." Dr. S. Buford Word will preside.

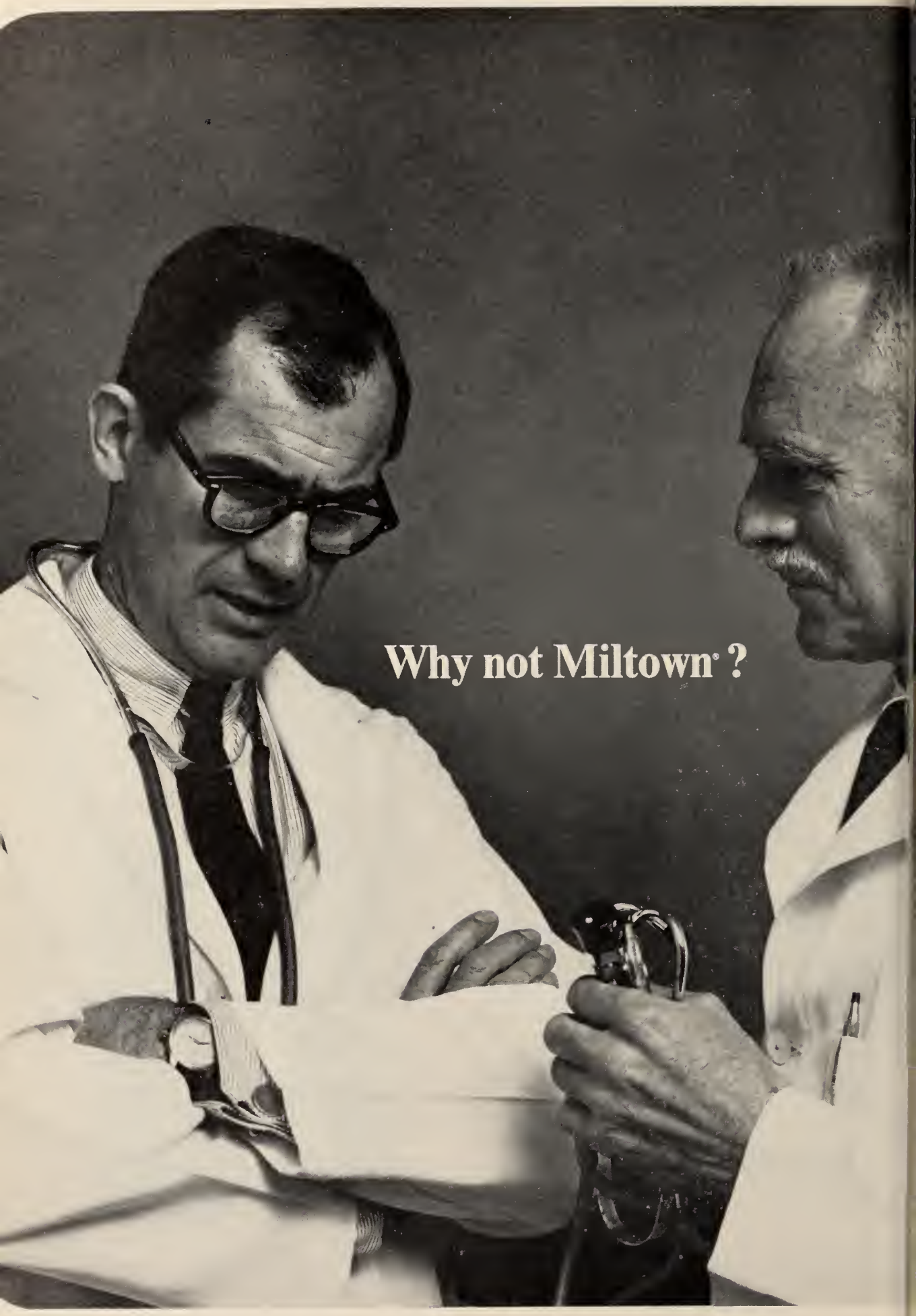
The program will continue after lunch with talks by Dr. John C. Hope, Jr., and Dr. O. M. Otts, Jr., of Mobile (Genital Fistulae from Obstetrical Causes), by Dr. W. N. Jones, professor, obstetrics and gynecology at the Medical College of Alabama (The Etiology of Genital Tract Fistulae in the Gynecological Patient), by Dr. David L. Barclay, assistant professor, obstetrics and gynecology, Tulane University (The Repair of Genital Tract Fistulae), by Dr. Julian P. Hardy of Birmingham (Restoration of Function in Treatment of Cyst and Abscess of Bartholin's Gland), by Dr. Robert V. Barnett of Birmingham (Amenorrhea and Birth Control Pills), by Dr. Donal E. Barlow of Sylacauga (The Actions and Side Reactions of the New Progestins), and by Dr. John D. Thompson, professor and chairman of the Department of Gynecology and Obstetrics at Emory University School of Medicine, Atlanta (Management of the Adnexal Mass).

Friday's program finds all sections meeting at the Parliament House at 9:00 a.m. for a program which will include addresses by Dr. Bruce Holding of Montgomery (Injuries of Face and Jaw), by Dr. Leroy D. Vandam, chief anesthesiologist, Peter Bent Brigham Hospital, Boston, Mass. (Lessons Learned in the Care of the Patient with Pulmonary Insufficiency), by Dr. Benjamin Felson, direc-

(Continued on Page 331)



DR. JOHN D. THOMPSON


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(1) *Bibby, Basil G. D.M.D., PH.D., et al "Evaluation of Caries-Producing Potentialities of Various Foodstuffs" Jl of Am Dent Assn; vol 42, May '51, pps 491-509*

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DR. BRUCE HOLDING



DR. LEROY D. VANDAM

tor of the Departments of Radiology at Cincinnati General Hospital, Holmes, Drake, Children's and Dunham Hospitals (Some Fundamentals of Chest Roentgenology), by Dr. William L. Glenn, professor of surgery and chief of the Cardiovascular Section, Yale University (Alexis Carrell—His Contribution to Tissue Transplantation and Blood Vessel Surgery), by Dr. James P. Marr, Woman's Hospital, New York (Alabama's Greatest General Practitioner—J. Marion Sims).

Also scheduled Friday morning is the Jerome Cochran Lecture. It will be given by Dr. W. M. Christopherson, professor and chairman of the Department of Pathology at the University of Louisville School of Medicine. "Early Diagnosis of Cancer" is the topic and Dr. Christopherson will be introduced by Dr. J. A. Cunningham of Birmingham.

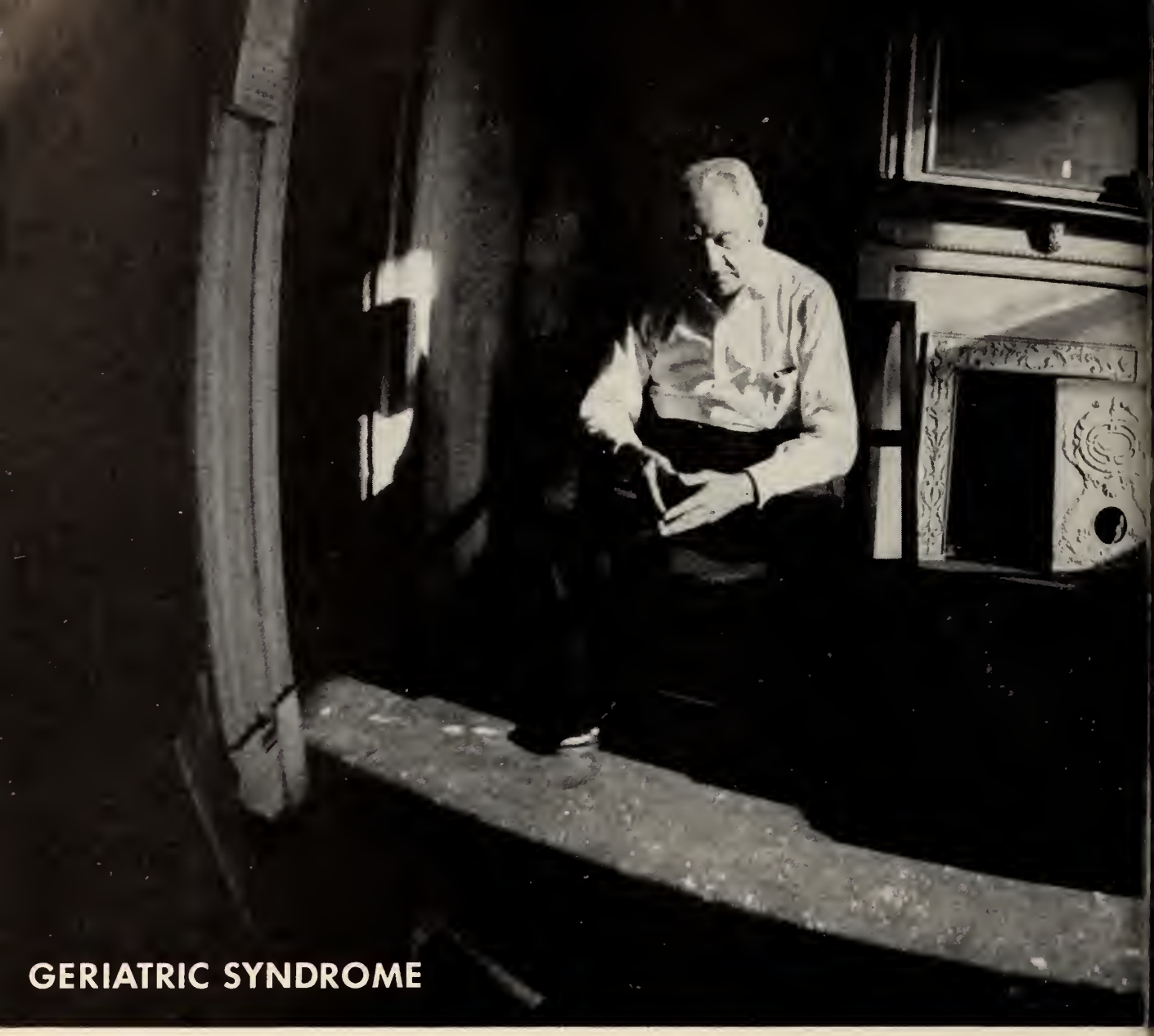
Other activities Friday morning include the recognition of the Fifty Year Club, presentation of the William Crawford Gorgas Award



DR. BENJAMIN FELSON



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DR. DAVID M. WITTEN

and the Douglas L. Cannon Medical Reporter Award, and recognition of fraternal delegates.

Friday afternoon finds the session divided into the three sections again, all meeting in the same locations as Thursday afternoon.

The Surgical Section will be presided over by Dr. F. C. Wilson, Sr., and will hear talks by Dr. David M. Witten, consultant at the Section of Diagnostic Roentgenology at Mayo Clinic and instructor in radiology at the Mayo Graduate School of Medicine (Mammography



DR. WILLIAM H. HARTMANN



DR. WILLIAM J. PITTS



DR. A. EARL WALKER

in the Study of Breast Diseases), by Dr. William H. Hartmann, surgical pathologist at Johns Hopkins Hospital and assistant professor of pathology at Johns Hopkins School of Medicine (Lobular Carcinoma "in Situ" of the Breast), by Dr. William J. Pitts, clinical instructor of surgery at the Medical College of Alabama (The Pernicious Pigmented Mole) and by Dr. A. Earl Walker, chairman of the Department of Neurosurgery at Johns Hopkins Hospital (Metastases from Primary Cerebral Tumors).

Friday's Medical Section program will be presided over by Dr. W. B. Frommeyer, Jr. It will include speeches by Dr. Benjamin M. Felson of Cincinnati (Some Fundamentals of Chest Roentgenology in Regard to Malignancies), and by Dr. Charles M. Huguley, Jr., associate professor of medicine at Emory University School of Medicine (Newer Concepts of Chemotherapy in Leukemia).

The Obstetrical and Gynecological Section Friday will find Dr. Word again presiding. The luncheon speaker will be Dr. David L.



DR. CHARLES M. HUGULEY, JR.



DR. OTTO C. PHILLIPS



Dr. Herbert Longenecker, president of Tulane University, is surrounded by a group of "old grads" from the New Orleans University at a recent meeting of the Tulane Alumni group in Montgomery. Standing, left to right, are Dr. Harry Glazer, Dr. Francis Thigpen, Dr. David Monsky, Dr. Forrest Little, Dr. Phillip Burwell and Dr. James Hicks. Seated are Dr. Farris Martin, Dr. Roger Nodine, Dr. Longenecker and Dr. Harris Dawson. Dr. Hicks is from Birmingham, the remainder of the physicians from Montgomery.

Barclay of Tulane University (Obstetrical Emergencies).

Afternoon speakers include Dr. Otto Charles Phillips, McGee Hospital for Women at Pittsburgh, Pa., and the University of Pittsburgh (Resuscitation of the Newborn), and by Dr. John D. Thompson of Emory University.

Friday afternoon at 3:30 p.m. all sections will meet at the Parliament House for a panel discussion on "New Concepts in Diagnosis and Treatment of Malignancies." Dr. Champ Lyons of the Medical College of Alabama will preside and panelists will include Drs. Christopherson, Roth, Huguley, Hartmann, Witten, Pitts, Walker, and Barclay.

Saturday finds the Association meeting at the Parliament House to sit as the Board of Health of the State of Alabama.

It will hear a report from the Board of Censors, will tackle revision of the rolls of county societies, counsellors and correspondents, will elect and install new officers, and present the past-president's plaque.

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Ladies To Have Their Convention, Too



MRS. WILLIAM H. EVANS

It will be Ladies Day at the Sheraton Motor Hotel April 22-23 when the Women's Auxiliary of the Medical Association of the State of Alabama holds its annual meeting.

In addition to such normal business procedures as the election and installation of officers, the reading of committee reports and the adoption of the budget, the ladies will be treated to two fashion shows as well as a lively sprinkling of other social activities.

Mrs. L. H. Clemmons, the outgoing president of the auxiliary, will preside.

Among the speakers for the program are Dr. E. B. Glenn, president of MASA; Mrs. H. Price Edwards, president of the Jefferson-Birmingham Auxiliary; Mrs. Jordan Kelling of Waverly, Mo., president of the Woman's Auxiliary of the Southern Medical Association; Dr. S. Richardson Hill, dean of the Medical College of Alabama; Mrs. William H. Evans, president of the Woman's Auxiliary of the American Medical Association, and Dr. Aubrey S. Miree who will give a talk on child psychiatry.

Sandwiched between these activities, the 2,000 doctors' wives expected to attend the annual session are invited by Birmingham stores and restaurants to make themselves right at home and enjoy the many hospitality activities which abound in the Magic City.

Pre-convention activities will begin Wednesday, April 21, when the organization holds a Board meeting at the Sheraton's Hunt Room beginning at 3 p.m.

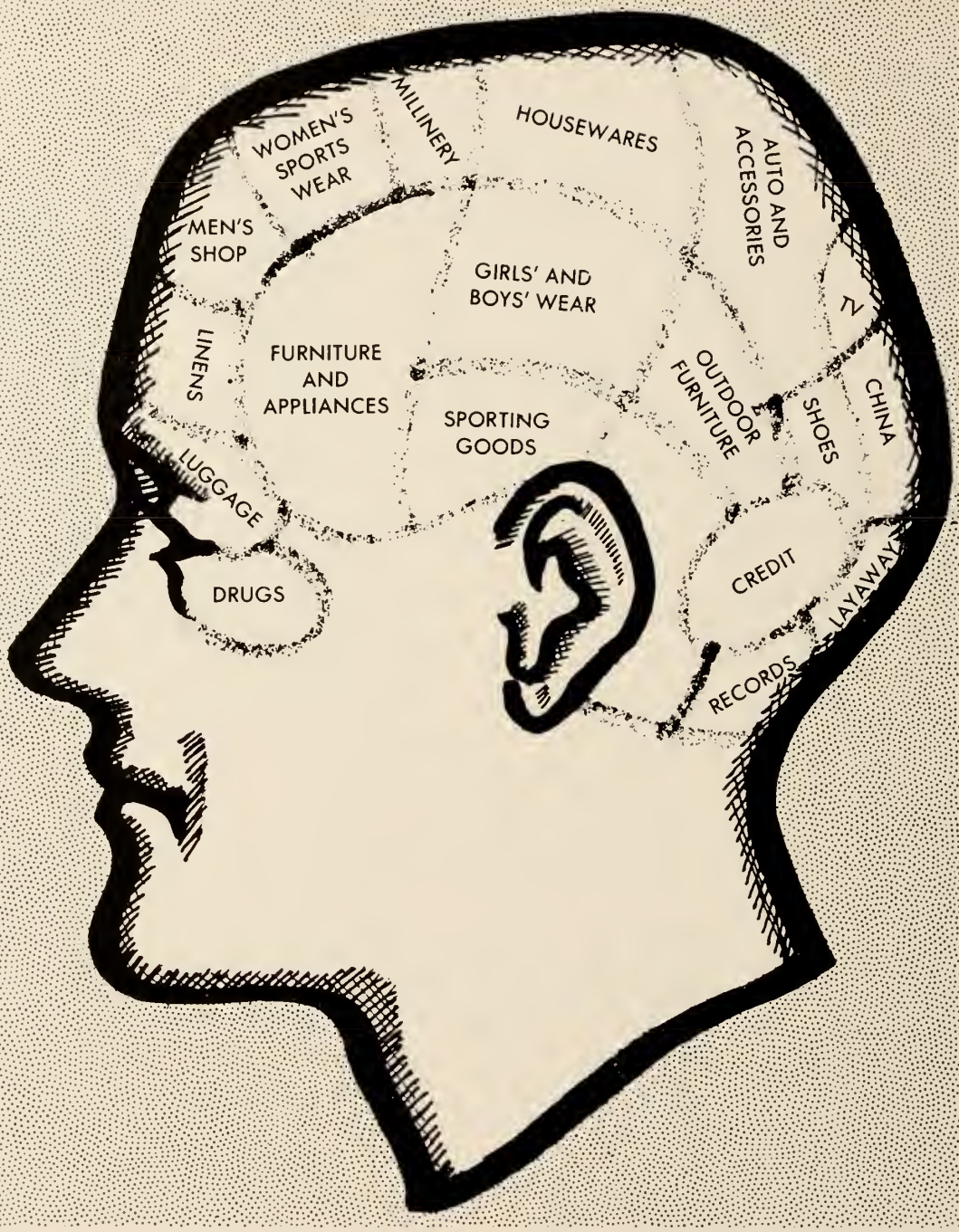
Registration also will begin Wednesday at 3 p.m. at the Sheraton and also at the lobby of the Parliament House, headquarters for the MASA annual session.

Among the varied social events scheduled for the ladies is entertainment by the Scroll and Key Club Friday evening at the Vestavia Country Club. Cocktails will be served at 6 p.m., dinner at 7 p.m. and a dance at 9 p.m.

Mrs. Gilder L. Wideman is general chairman of the Jefferson County Committees for the convention with Mrs. Joseph Campbell serving as co-chairman.

Included in the Woman's Auxiliary program will be committee reports by Mrs. R. K. Wilson and Mrs. Bluitt Landers and the annual report by officers.

Making their annual reports will be Mrs. L. H. Clemmons, president; Mrs. James F.



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No, not of materia medica at the moment, but the materia basic of everyday living. Think of getting the most for your shopping dollar! Think of famous brands! Think of customer satisfaction and service! Think of 24 hour 'round the clock telephone service! Think of convenient credit plans tailored to any budget! Think of over 100 departments in 4 conveniently placed department stores! Think of low prices, every day in the year—not just at end-of-season clearances! Think of convenient parking! You'll agree—at the end of all the thought processes—they all add up to the store with a "spark in its bloodstream"—think

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- Birmingham
- Bessemer
- Roebuck
- Huntsville

Crenshaw, president-elect; Mrs. Eugene Bradley, Northeast District; Mrs. C. V. Hendrix, Blount County; Mrs. Warren G. Sarrell, Calhoun; Mrs. W. J. Campbell, Cherokee; Mrs. William Noble, DeKalb; Mrs. A. C. Collins, Jackson; Mrs. B. B. Jordan, Madison; Mrs. L. F. Corley, Jr., Marshall, and Mrs. James Wright, Talladega.

Mrs. E. F. Campbell will report for the Southeast District along with Mrs. John M. Kimmey, Coffee; Mrs. A. B. Lee, Covington; Mrs. John Bennett, Elmore-Tallapoosa; Mrs. Robert Martin, Jr., Geneva; Mrs. Ben Byrd, Houston; Mrs. Frank C. Miles, Montgomery, and Mrs. J. O. Colley, Jr., Pike.

Mrs. William P. Batson will report for the Southwest District along with Mrs. Hyman Abrahamer, Baldwin; Mrs. George B. Nicholson, Dallas, and Mrs. Robert L. Brier, Mobile.

• • •

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Could be. My problem hypertensive finally came around.



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Composition: Each tablet contains chlorthalidone, 50 mg., and reserpine, 0.25 mg.
Contraindications: History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.
Warning: Discontinue 2 weeks before general anesthesia, 1 week before electroshock therapy, and if depression or peptic ulcer occurs.
Precautions: Reduce dosage of concomitant antihypertensive agents by one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take particular care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.
Side Effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.
For full details, see the complete prescribing information.

Average Dosage: One tablet daily with breakfa
Availability: Bottles of 100 and 1000 tablets.

*Chupkovich, V.; Finnerty, F. A., Jr., and Kakaviatos, N.: The value of chlorthalidone plu reserpine in moderately severe and severe hyp tension: A two year study. Presented at the 7th Inter-American Congress of Cardiology, Montr June 14–19, 1964.

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Dr. Donald To Serve As Next President Of Association

This time next month James Glenn Donald, M. D., F. A. C. S., of Mobile, will be the new president of the Medical Association of the State of Alabama. Dr. Donald, who was named president-elect of the Association last year, will be installed as president during the annual session in Birmingham, April 22-24.

Born in Pine Apple, Ala., on November 20, 1916, his father and both grandfathers were doctors. Three paternal uncles and many cousins have practiced medicine in Alabama.

After graduation from high school, Dr. Donald entered the University of Alabama where he obtained his A. B. degree in 1936. His M. D. degree was obtained from the School of Medicine, University of Pennsylvania, in 1940. Following this, he was an intern at the Hospital of the University of Pennsylvania from 1940-42; served as a Surgical Officer, United States Army, 20th General Hospital (affiliate of the University of Pennsylvania), serving in Assam, India, from 1942 to 1945. His residency in surgery was at the Hospital of the University of Pennsylvania under Dr. I. S. Ravdin from 1946 through 1948.

He began his surgical practice in Mobile, Alabama, in 1948, and has continued until the present time. He is associated in practice with his brother, Dr. John W. Donald.

Dr. Donald is a member of the active staff of Mobile Infirmary, Mobile General Hospital, Providence Hospital, all in Mobile, Alabama.

He is a member of the Mobile County Medical Society, American Medical Association, and Southern Medical Association. He was certified by the American Board of Surgery in 1949, and became a Fellow of the American College of Surgeons in 1949. He was elected to Fellowship in the Southern Surgical Association in 1953, and he served as President, Alabama Chapter, American College of Surgeons in 1964.



DR. JAMES GLENN DONALD

Your new president served as chief of the Surgical Service and chairman of the Department of Surgery at Mobile General Hospital from 1958-1963. During this time he was in charge of the surgical residency training program at Mobile General Hospital.

He served as a member of the Blue Cross-Blue Shield Committee of the Medical Association of the State of Alabama from 1958-1961 and was chairman of this committee in 1961. He also served on the Committee on Medical Education and Hospitals and the Committee on Public Relations of the Medical Association and has been a Counsellor of this Association since 1959.

Dr. Donald is married to the former Gretchen Brooks of Drexel Hill, Pennsylvania. They have three sons: James, Jr., age 18; Brooks, age 15; and Thomas Curry, age 12. The family resides at 17 Kingsway, Mobile.

Dr. Donald is a member of the Board of Deacons, First Baptist Church, Mobile, and the Board of Directors, Mobile Opera Guild.

President's Page

This is the last President's Page for the writer. It has been a pleasant task and it has provided a means to keep the membership informed of what has been felt to be significant.

The major problem that has faced the Association and all of organized medicine this year has been opposition to the King-Anderson Bill in the 88th Congress, and later, the battle against the second King-Anderson Bill, or HR-1 and S-1, in the 89th Congress.

The AMA's Eldercare program gave us a tool with which to oppose "medicare." If the profession had felt it had been necessary to push such a program for the past several years "Medicare" probably would never have gotten such a hold in the minds of the public. Misjudgment as to the extent of the landslide with which Lyndon Johnson entered office this year led to a "hurry-up" method of opposing the Aministration's "foot-in-the door" plan for the beginning of the socialization of medicine.

One of the most significant documents that indicates the intentions of the Liberals in directing the future of this nation is the address of Arthur E. Hess, Director, Division of Disability Operations. Social Security Administration entitled "Administration of a Federal Hospital Insurance Program for the Aged." This was delivered to the American Hospital Association's Conference of Presidential Officers and Executives of Allied Hospital Associations in Chicago, February 4, 1965.

Among the many parts of the Administration's directive has been a very significant one, *"To begin with, every hospital would automatically be able to participate if it wished—providing only that the hospital have an arrangement to review utilization of services."* It further states that in the case of smaller hospitals not reviewed by the Joint Commission the County Medical Society should set up a utilization committee for several hospitals in the area.

At the Blue Shield Annual Program Conference in Chicago, October 12-13, 1964, Dr. James C. Doyle, President of the California Medical Association gave a paper entitled "A Survey of Attitudes about Health Care." One of the questions asked 532 members of two hospital staffs was the opinion they had concerning the effectiveness of a utilization committee. Forty four per cent indicated the utilization committee was effective in evaluating *reasons* for hospitalization while 35 per cent thought such a committee had no value in this respect. Over 20 per cent had no opinion on the matter.

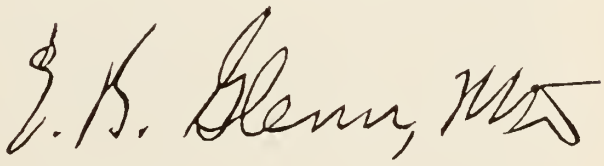
In evaluating the length of stay of patients, 42.4 per cent felt that the committee was effective but 37.3 per cent did not consider such a committee worthwhile. Effective May 1, New Jersey Blue Cross is putting into effect a contract based on length of stay according to the diagnoses. (Taken from records of 300 diagnoses using the average length of stay of each as a basis.) A.I.D. (Approved by Individual Diagnosis). The Medical Association, the Hospital Association, and Blue Cross-Blue Shield put this together. The attending physician is to certify that the patient should be hospitalized longer if further hospitalization is necessary for proper care.

The writer has been chairman of the "Admissions and Utilization Committee" of St. Vincent's Hospital, Birmingham, for the past five years. Experience has shown that "reasons for admission" and "length of stay" must be combined. Admissions are given priority as follows: (1) Emergency, (2) Urgency, and (3) Elective. On the other hand, a 10-day patient stay list is made by each floor on Monday and evaluated by the chairman of the committee. This averages from 30 to 39 patients out of 189 beds who are listed over 10 days. The admitting diagnosis is confirmed or changed by asking the attending physician in a questionnaire "Please give the present diagnosis and the reason for the prolonged stay." A second question is asked, "When is discharge contemplated or please give the reason for being unable to estimate

this?" The Administrator countersigns this request for information.

The average letter is not sent until the patient has been in the hospital at least 18 to 21 days. In some instances such as acute coronary occlusion, no letter is sent under 30 days. The staff is co-operative and once a reply is received no further letters are sent as a rule.

There is an irreducible minimum of patients that cannot be moved. The Federal Regulation has indicated it will insist on a 21 day review and, if the utilization committee decides that the patient should be discharged, funds will be cut off. A great deal of "red tape" will be required to administer such a program plus running the risk of dictating to the physicians of this country how to manage their patients. The system at St. Vincent's Hospital is a means of providing a basis for communication between the management of the hospital and the practicing physician and that is all.



Now We Have Classifieds!

With this issue, the JOURNAL inaugurates a classified advertising column for the convenience of members of the Medical Association of the State of Alabama. Doctors having anything they want to buy, rent or sell, or who desire to advertise for physician placement are invited to submit copy to our editors. Charges for such ads will be 50c per line per issue.

* * *

General Practitioner urgently needed to associate with very busy established practitioner in West-central Texas town of 7,000. Salary or guaranteed income until practice builds up. New offices across street from open-staff 38-bed hospital in which you will have full privileges with a Texas license. Reply to Edwin Goodall, M. D., 201 South Geneva, Breckenridge, Texas, 76024.

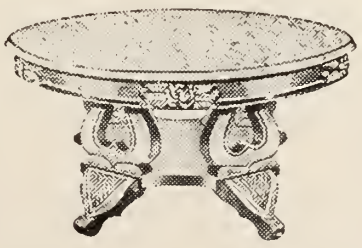
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"All Registered Nurses are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests: they all have to measure up to the same standards. Therefore, all registered nurses are alike.

That's nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all registered nurses aren't alike, either.





around the state

Alabama Doctors Figure Prominently in Community Health Program

The medical profession figures prominently in the formulation of a master plan for comprehensive community mental health services for Alabama.

Organizational meetings were held in February for seven task forces, each dealing with a different aspect of the overall plan. Around 300 prominent Alabamians are participating, representing a variety of disciplines. Each group has formed committees, and many meetings are being held to find answers to specific questions by May 31.

The task force work is an advanced phase of a two-year Grant-in-Aid program carried forward by the Division of Mental Health Planning, Alabama Department of Public Health, directed by Dr. William H. Tragle.

Physicians on Task Force I, Direct Patient Services, are Dr. Quintus Langstaff, Florence; Dr. Sidney B. Chenault, Decatur; Dr. James C. Folsom and Dr. J. E. Morris, Jr., both of Tuscaloosa; Dr. John D. Elmore, Birmingham; and Dr. Cecil H. Prescott, Montgomery.

Task Force II, Indirect Patient Services, includes Dr. Tragle, Dr. J. J. Kirschenfeld and Dr. H. Klingler, all of Montgomery; Dr. Glenn H. Baird, Dr. W. G. Thuss, Jr., and Dr. J. C. Chambers, all of Birmingham; Dr. Gerald J. Margolis, Maxwell Air Force Base, Dr. Dixon Meyers, Mobile; Dr. William B. Robinson and Dr. Robert Webb, both of Tuscaloosa.

Those on Task Force III, Extended Patient Services, are Dr. Morris B. Mann, Montgomery; Dr. Gonzalo G. Ochoa, Tuscaloosa; Dr. Virginia Webb, Gadsden; and Dr. Fay W. Doss, Birmingham.



Dr. Henry Hodo of Fayette (left) is being congratulated on his installation as president of the Alabama Chapter of the American College of Surgeons by Dr. James G. Donald of Mobile, retiring president. Dr. Hodo was installed recently at a meeting of the organization in Point Clear.

Task Force IV, Training and Manpower participants are Dr. Franklin Jackson, Montgomery; Dr. F. J. Nuckols and Dr. Priscilla Keeler, both of Birmingham.

Task Force V, Research and Evaluation, includes Dr. Hugh Haden and Dr. Fritz Kant, both of Birmingham; Dr. Otto L. Burton, Montgomery; Dr. Sidney Williams, Livingston; and Dr. Daniel F. Sullivan, Mobile.

On Task Force VI, Professional and Agency Relationships, are Dr. Walter Batson and

Dr. J. K. Ward, both of Birmingham; Dr. Sam T. Simpson, Dothan; Dr. Donald Smith, Tuscaloosa; Dr. B. H. Johnson, Jr., Bessemer; Dr. Claude L. Brown, Mobile; and Dr. Paul Auston, West Point, Ga.

Task Force VII, Legal Consideration participants are Dr. John M. Chenault, Decatur; Dr. H. H. Hutchinson, Montgomery; Dr. Albert B. Stephens, Birmingham.

The variety of professions represented on the task forces includes pharmacy, banking, the ministry, social work, the legal profession, law enforcement, journalism, education and architecture. Psychiatrists, psychologists, industrialists and personnel executives are participating.

Available for construction for the current fiscal year is $778,000 in federal money, under the 1963 Mental Health Construction Act. During the coming year, beginning July 1, Alabama will probably have an additional $1 million available, to be matched with one dollar of state or local funds for every two of federal money. Expectations are to have the plan ready for action by June 30. A plan for construction, developed by the Division of Hospital Planning, will accompany the master plan.

Among questions to be answered in the plan are where the facilities will be located and how the services will be related to others already established.

Dr. R. W. Binger Opens Practice In Huntsville

Dr. Richard W. Binger has begun medical practice in Huntsville in association with Dr. Eugene L. Tate.

Dr. Binger is a graduate of Vanderbilt University and the Tennessee School of Medicine. He interned at John Gaston Hospital in Memphis and recently completed a four-year residency in ear, nose and throat medicine at Memphis' Kennedy Hospital.

DR. HARPER HONORED BY COLBERT SOCIETY

Dr. R. E. Harper recently was honored by the Colbert County Medical Society when he resigned as secretary-treasurer after serving in that position for the past 27 years.

Dr. Howard Johnson, president of the society, presented Dr. Harper with a desk set with an engraved plaque setting out the years he had served the society. He will be replaced as secretary-treasurer by Dr. R. E. Campbell.

Dr. Harper has served as a health officer in northeast Alabama since 1925, listing Lawrence, Colbert, Lauderdale and Franklin Counties among his areas served. He will continue in his duties as a county health officer and now is the oldest health officer in point of service in the state.

Children's Hospital Staff Honors Dr. Hughes Kennedy

The staff of Birmingham's Children's Hospital recently honored Dr. Hughes Kennedy, Jr., for "40 years service to the community and his contribution to better child health."

Nursing Home Dedicated

The new Shelby Memorial Nursing Home at Alabaster was dedicated January 31 with Rep. Armistead Selden (D-Ala) delivering the main address. The new 40-bed home is attached to the Shelby Memorial Hospital and had its final inspection February 4.

Jasper Hospital Inspected

Final inspection of the new Jasper Community Hospital was held February 4. The $444,740 project provides nine new beds for a total of 64, modern facilities for emergency treatment, a new delivery suite, nursery and obstetrical beds, a new operating suite and laboratory.



Dr. Donovan Ward, extreme left, president of the American Medical Association, spoke last month at a meeting of the Jefferson County Medical Society in Birmingham which attracted hundreds of medical men from throughout Alabama. Shown above with the AMA chieftain are, left to right, Dr. William Lawrence, president of the Jefferson County Society; Dr. Ira Myers, state health officer; Dr. E. B. Glenn, president of the Medical Association of the State of Alabama; Dr. Garber Galbraith, president-elect of the Southern Medical Association, and Dr. C. W. Neville, president-elect of the Jefferson County Society.

The ladies had their day, too, as Mrs. Ward was entertained at a tea given by Mrs. Glenn. Shown below, left to right, are Mrs. Lawrence, Mrs. Ward and Mrs. Glenn.



GOOD ENOUGH

(From *The Andalusia Star-News*)

Every surgeon and physician in Covington has endorsed "Eldercare." All oppose "Medicare." This is good enough for us. We intend to roll the drums in opposition to any new tax to finance LBJ's "Medicare."

Dr. Frederic N. Silverman Speaks To Jeffco Society

Dr. Frederic N. Silverman, noted Cincinnati pediatrician and X-ray specialist, recently addressed the Jefferson County Medical Society and delivered two speeches at Birmingham's Children's Hospital.

Dr. Silverman, who is attending physician and director of the division of roentgenology at the Children's Hospital in Cincinnati, spoke on chest diseases of childhood and on children's abdominal diseases while at the hospital. His topic at the society was "X-ray Examination in Urinary Tract Infection in Childhood."

Dr. Fernandez Opens Practice

Dr. Gabriel L. Fernandez, formerly at the University Hospital in Birmingham, has begun practice of neurosurgery at Tuscaloosa.

Association Officer Speaks At Mosquito Conference

William V. Wallace, executive secretary of the Medical Association of the State of Alabama, recently addressed a conference of medical and public health leaders at a conference on mosquito eradication.

Wallace spoke on administrative aspects of arousing and directing public opinion. The meeting was sponsored jointly by the American Medical Association and the Communicable Disease Center of the U. S. Public Health Service.

Immunization Seminar Held In Birmingham

A seminar on immunization, sponsored jointly by the Communicable Disease Center of the Public Health Service and the Alabama Chapter of the American Academy of Pediatrics with the cooperation of the Jefferson County Health Department, was held in Birmingham last month.

Dr. Edward A. Harris presided over the seminar's morning session while Dr. J. Carroll Chambers headed up the afternoon discussions.

Appearing on the program were Dr. John J. White, Dr. Philip A. Brunell, Dr. Lewis L. Coriell, Dr. Sarah H. Sell, Dr. John M. Neff and Mr. Ray Overton.

Three To Address Orthopaedic Society

Three nationally famous speakers will address the Alabama Orthopaedic Society at its meeting Wednesday, April 21 at 1 p.m. at the Parliament House in Birmingham. The meeting is being held in conjunction with the annual session of the Medical Association of the State of Alabama.

Scheduled to address the group are Dr. John J. Killeffer of Chattanooga, Tenn., Dr. F. James Funk of Atlanta and Dr. Samuel B. Thompson of Little Rock.

Dr. Thompson now is president-elect of the American Academy of Cerebral Palsy. He began his medical career as an intern at Lloyd Noland Foundation in Fairfield, Ala.

Dr. Funk has received national recognition for his work in Haiti over a period of several years and has gained considerable knowledge as a result of this work in the management of bone tuberculosis, including Pott's disease.

Dr. Killeffer is an internationally known orthopaedic surgeon in the field of surgical management of cervical radiculitis.



Dr. H. Earle Conwell, associate professor emeritus of orthopedic surgery at the Medical College of Alabama, is shown above after being honored by several of his former residents. The group placed the Nicholas Andre Symbol of Orthopedic Surgery in the Medical Center's Lawrence Reynolds Library in honor of Dr. Conwell. Those honoring their former teacher included Dr. Rufus H. Allredge of New Orleans, Dr. Francis J. Cox of San Francisco, Dr. E. Crampton Harris, Jr., and Dr. T. J. Bender, Jr., both of Mobile, Dr. Benjamin J. Meyer and Dr. David G. Vesely, both of Birmingham. Dr. Conwell is shown above (left) with the plaque and with Dr. S. R. Hill, dean of the Medical College.

Dr. H. Earle Conwell Honored By Walker County Group

Dr. H. Earle Conwell of Birmingham recently was honored by the Walker County Society for Crippled Children and Adults at Oakman, Ala.

The society noted that Dr. Conwell and his staff have attended every crippled children's clinic held in Walker County and honored the Birmingham orthopedic surgeon at a testimonial luncheon following the February clinic.

Walker County has been sponsoring two clinics yearly since 1930.

Final Programs Scheduled In ETV Diabetic Series

The final two programs in the educational television series, "The Diabetic Life," will be presented over the state's ETV network April 14 and 21.

The April 14 program, entitled "Research In Diabetes," will feature discussions by Dr. Buris Boshell, Dr. C. K. Meador, Dr. William L. Hawley and Dr. Theodore S. Cone.

The April 21 program, "History of Diabetes Mellitus," will present talks by Dr. L. S. Smelo and Dr. Boshell.

The series is sponsored by the Alabama Diabetes Association and the Medical College of Alabama and is presented Wednesdays at 9 p.m. over channels 2, 7, 10 and 26.



Be alert to Cancer's Seven Danger Signals

1. Unusual bleeding or discharge
2. A lump or thickening in the breast or elsewhere
3. A sore that does not heal
4. Change in bowel or bladder habits
5. Hoarseness or cough
6. Indigestion or difficulty in swallowing
7. Change in a wart or mole

See your doctor immediately if any of Cancer's Seven Danger Signals lasts more than two weeks.

See your doctor every year for a health checkup.

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Diothane—with its chemically distinct "non-caine" anesthetic agent diperodon—provides effective temporary topical anesthetic and emollient actions for soothing relief of anorectal pain. Anesthetic activity is effective and relatively prolonged; sensitization is infrequent. Reports to Merrell on 1,500 patients treated pre- and postoperatively with Diothane Ointment, indicate only 22 developed local skin reactions. Reactions to Diothane have been burning or stinging sensations and a few cases of allergic manifestations. An additional advantage: Diothane Ointment and Suppositories are mildly antiseptic. Prescribe or recommend either form...both are now available.

DIOTHANE OINTMENT

COMPOSITION:
diperodon 1.0%; oxyquinoline benzoate 0.1% in a special ointment base.

INDICATIONS:
Provides temporary palliation of pain that may result from hemorrhoidectomy and from common anorectal disorders such as hemorrhoids, anal fissures, pruritus ani.





DIOTHANE SUPPOSITORIES

COMPOSITION:
Each suppository, weighing approximately 2.6 Gm., contains diperodon 1.0%; urea 10.0%; oxyquinoline benzoate 0.1% in a special hydrophilic suppository base. A unique shape keeps the suppository in intimate contact with mucous membranes.

INDICATIONS:
Provide for temporary palliation of pain caused by hemorrhoids and pruritus ani.

Merrell

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The Committee on Medical Education and Hospitals of the Medical Association of the State of Alabama met recently in Birmingham. Members and guests shown above are, left to right, Dr. Joseph Volker, Miss Parnell Langston, Dr. Margaret Klapper, Dr. Ernest Majure, Dr. Lamar Ager, Dr. William L. Hawley, Dr. Robert Roth and Dr. William Ward.

THREE CONGRESSMEN REPLY TO APPEAL BY GLENN ON HEALTH CARE LEGISLATION

CONGRESSMEN REPLY: In response to a telegraphed appeal by Dr. E. B. Glenn, president of MASA, to members of Congress asking them to request a public hearing on any health care legislation reported out by the Ways and Means Committee the following congressmen replied:

REP. GEORGE ANDREWS:—"I am today taking your request up with Honorable Wilbur Mills, Chairman of the Committee, to urge that favorable action be taken on your recommendation."

REP. BOB JONES:—"I shall give the closest scrutiny to all of the proposals for medical care for our aged citizens . . . and I shall vote for the proposal that I feel best for Alabama and the nation. In an effort to accommodate you and the many other people that have communicated with me regarding the Eldercare proposal, I am contacting Chairman Wilbur Mills . . . and urging him to give special attention to the merits of the Eldercare Bill."

REP. JACK EDWARDS:—"I am going to do everything I can to insure that Congress has the opportunity to vote on the Eldercare Bill. . . . This appears to be one of the best proposals I have heard so far."

Report On Nigerian Trip Given By Dr. Phillips

Dr. Carey Phillips of Birmingham recently told the Ensley Rotary Club of his experiences on a recent trip to Nigeria where he and other physicians gave relief to medical missionaries.

The doctors pay their own expenses while on the mercy mission sponsored by the Southern Baptist Missionary Convention.

Doctors Answer Questions For Arthritis Foundation

Four Alabama doctors recently appeared before a meeting of the Arthritis and Rheumatism Foundation in Montgomery to answer a barrage of questions concerning the diseases and their treatment.

Appearing were Dr. Ross McBryde, Dr. M. V. Parker and Dr. Randolph Penton of Montgomery and Dr. Robert S. Hogan of Birmingham.

Fire Destroys Office Of Jasper's Dr. O'Rear

The office of Dr. Ed A. O'Rear of Jasper was destroyed by an early morning fire recently causing damage estimated as high as $35,000.

Firemen were able to save some of Dr. O'Rear's records but all equipment in the building was destroyed.

Birmingham Doctors Address Family Living Workshop

Three Birmingham doctors—Dr. Herbert W. Eber, Dr. Lewis S. Chase and Dr. Samuel Harris—recently addressed a meeting of the annual Birmingham area Marriage and Family Living Workshop.

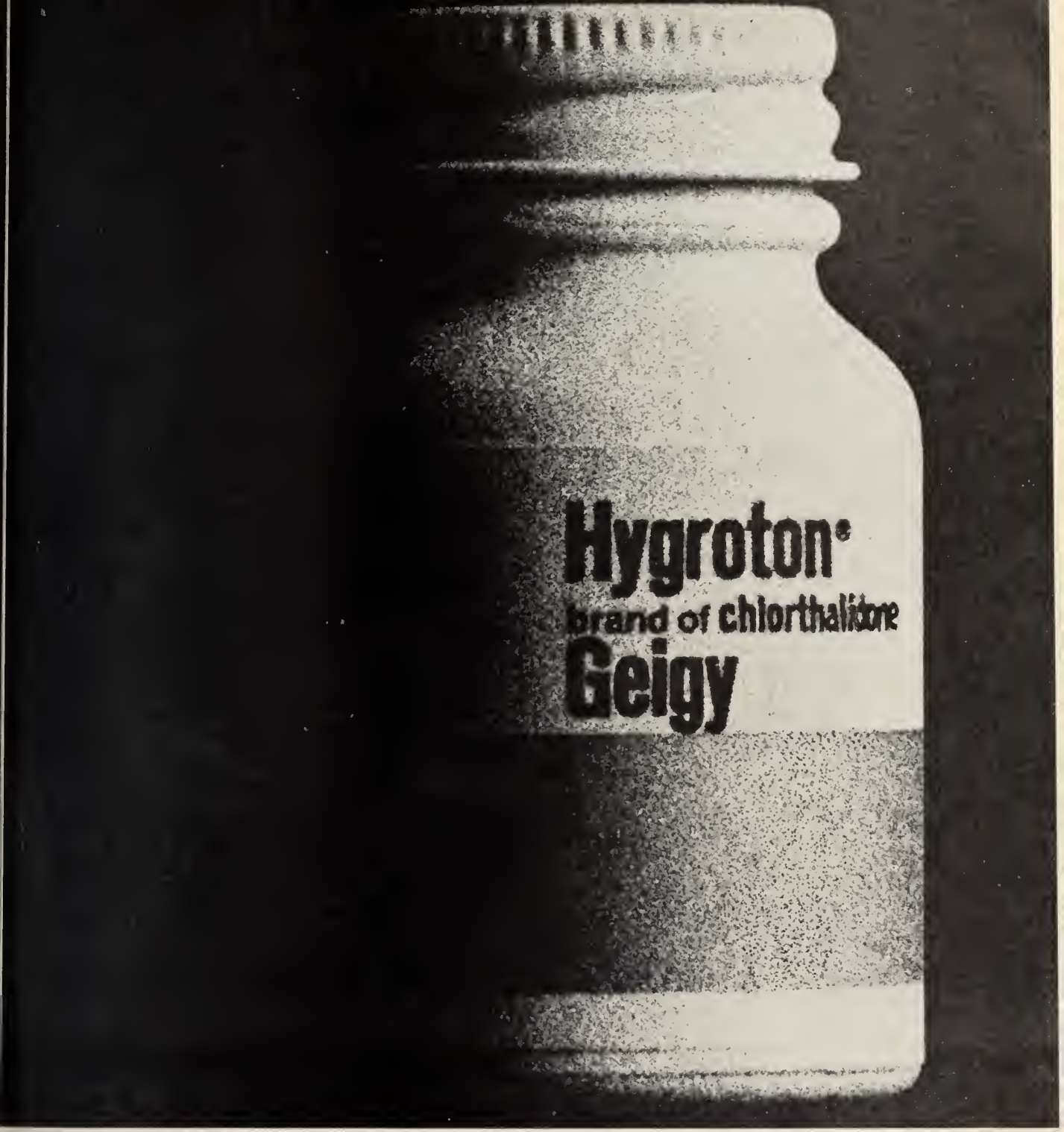
Dr. Eber's subject was "Emotional and Sexual Fulfillment in Marriage," Dr. Chase discussed, "When The Emotions and Mind Make The Body Sick," and Dr. Harris spoke on "Parent-Child Relationship."

Indications: Many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.
Precautions: Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.
Side Effects: Agranulocytosis, constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, impotence, leukopenia, muscle cramps, nausea, postural hypotension, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
Average Dosage: One tablet (100 mg.) daily with breakfast.
Availability: Tablets of 100 mg. in bottles of 100 and 1000.
For full details, see the complete prescribing information.

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Hygroton®
brand of chlorthalidone

The long-acting diuretic



who needs it?

Patients with edema.
Edema in congestive heart failure.
Or in the premenstrual syndrome.
Edema in pregnancy...or obesity.
Patients you want to bring to dry weight.
And those you want to keep at dry weight.
Those you want on single daily doses.
And those requiring even fewer doses.
Those resistant to other therapy.
And those intolerant of other diuretics.
Those who have to pinch pennies.
And those who can afford the best.

Medical Assistants Draw Picture Of The Ideal Doctor

CHICAGO—The physician who wonders how he rates with his employees now has a yardstick with which to measure his standing.

Fifty medical assisting students in three schools around the nation have drawn a picture of what they consider to be the ideal MD-boss.

He is a kindly, pleasant, dedicated man who runs his practice efficiently and who treats his employees with consideration, taking time to explain duties, to criticize constructively, and to show occasional appreciation for a girl's devotion to her work.

The American Association of Medical Assistants interviewed women selected at random in medical assisting courses at Southwestern Preparatory School, Phoenix, Ariz., Foothill College, Los Altos Hills, Calif., and the Madison (Wis.) Vocational and Adult School and asked them to list the qualities they felt were most important in a physician-employer.

Mentioned most often was "a nice personality." Second on the list was consideration —for employees as well as patients. Third was efficiency, the ability to organize the office and run it smoothly. Proficiency in medicine was fourth on the list, although it is quite likely students assumed that all physicians would meet this requirement.

Mutual respect for each other and an appreciation on the part of the physician for the special skills and training of the modern medical assistant were cited next in importance.

Other desirable qualities sought in doctor-bosses included kindness, patience, understanding, tolerance, honesty, fairness, tact, a sense of responsibility, neatness, promptness, high morals and ethics, and a belief in God.

Medical Assistants said they wanted an employer who was understanding, able to give directions, but who would not "watch them like a hawk." Others said he should be patient, particularly when a girl is new on the job, and willing to explain things to her.

Many said he should be able to communicate his views and instructions clearly to his employees and several stressed the importance of keeping his office posted on his whereabouts. Here are some selected students' comments:

"The ideal physician-employer . . . would explain distinctly to his assistant what he wants her to do and what he doesn't want her to do."

"He . . . should be able to hand out criticism without hurting feelings and help straighten out matters when there is difficulty."

"He should allow his medical assistant to work at her own capacity and speed. He would have respect for her as a person as well as for her profession. He would have faith in her abilities and judgment."

Others say they want an employer who will not hesitate to criticize when necessary, but one who will not yell. The one quality all say they would dislike most in an employer is grouchiness.

A report on the survey appears in the January/February issue of the AAMA BULLETIN, publication of the American Association of Medical Assistants. The accompanying article encourages future medical assistants to analyze themselves to determine the type of physician for whom they could work best.

"In the medical office the ability to work together harmoniously is essential. The physician and his staff must work closely, often dealing with people who are not at their best. If there is friction or tension because of personal incompatibilities, the entire office operation suffers."

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When anxiety interferes with work, your patient needs a drug that will calm without causing undue drowsiness. With Stelazine (trifluoperazine, SK&F), you can promptly control the anxiety without producing the sedation seen with certain other agents. Anxious patients can remain active during therapy.



Stoll[1] used the drug in 50 patients with anxiety, and noted: "There was no drowsiness in this group of patients and, because of their alertness and less impaired concentration, they were able to continue with and, in some cases, return to their daily work."

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Before prescribing, see SK&F Product Prescribing Information.

Photograph professionally posed.

1. Stoll, L. J.: The Use of Trifluoperazine ['Stelazine'] in General Practice, M. Press *243*:578 (June 29) 1960.

SK&F **Smith Kline & French Laboratories, Philadelphia**

Medicare Under Social Security

By J. H. GOLDMAN

Aluminum Company Of America

Associated Industries of Alabama represents 961 member companies that employ over 675,000 men and women. These businesses all operate in Alabama communities that contain their own share of our senior citizens 65 years of age or older. It necessarily follows then, that the members of AIA are not only fully aware of the medical care problems of the aged but as corporate citizens of their communities have in the past, are now and will continue to promote and support programs in the public interest that are designed to aid those people who **NEED** help, whether it be medical or otherwise.

At the same time AIA believes that security, whether it be medical or economic, can best be assured by preserving for future generations the opportunity to reap the just rewards of ability and initiative within the framework of an economy that encourages individual enterprise. Such a framework certainly does not embody the concept or practice of any government, whether it be local, state or federal, employing the use of public funds to provide a static level of service or benefits to a segment of society on the basic qualification of age. For any such program involving expenditure of public funds to ignore the factors of individual need, individual financial participation and individual desires is to lead to an unnecessarily heavy burden on the taxpayer citizen. Relatively little good can result from such an indiscriminate distribution of public funds. Certainly such a program will completely destroy the incentive for the individual to make even normal preparations for his economic security in declining years. Rather he will be encouraged to further depend upon an all beneficent government to assume additional responsibilities not commensurate with a free society.

As I have stated, AIA is not unaware of the medical problems of a fraction of the nation's aged people. However, we submit that the problem is not of such magnitude that additional federal legislation is either required or desirable.

In 1960 the Congress initiated an entirely new federal-state grants-in-aid program of "Medical Assistance for the Aged," the so-called Kerr-Mills bill and provided for certain medical care to be given to Old Age Assistance recipients. The federal government finances 60 to 80 percent of the costs of these programs, the balance coming from the states that implement and control them. As of January 1, 1965, forty states had Medical Assistance for the Aged programs in effect. Three states have legal authority to implement a program but have not appropriated money for it. Seven states still need legislation.

An examination of the Kerr-Mills results reveals a need for certain changes in the law in order to cope with some of its inherent problems but the answer certainly does not lie in the practice of passing out a loaf of bread to everyone in a class in order to abate the pangs of hunger in a relatively few.

You have heard it before, but it bears repeating over and over again—this so-called Medicare approach embodied in S. 1 and H. B. 1. and other bills now before the Congress are but the first giant step toward nationalized or socialized medicine. To those who scoff and say, "it isn't so," take a look at most of the nations of Western Europe where such steps have been taken and where state medicine is deeply entrenched. In the United States during 1964 one out of every four dol-

Presented before the Alabama congressional delegation at the Washington meeting of Associated Industries of Alabama, Feb. 15, 1965.

lars spent for health and medical care was spent by government.

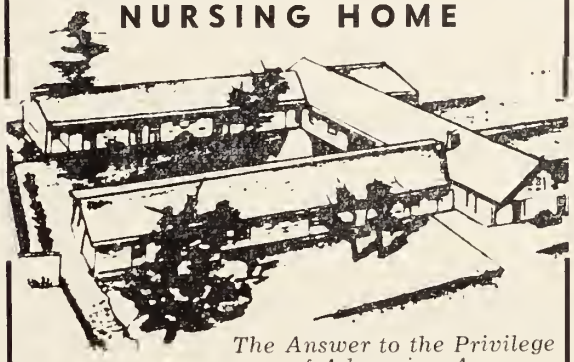
While AIA does not concede that any federal financing of health insurance is necessary, we recognize the popularity of such an approach, especially where the aged are involved. Therefore, we recommend that you gentlemen utilize all the skills with which you are endowed and the vote given you by the people of Alabama to oppose S. 1 and H. B. 1, so-called King-Anderson bill, and to oppose any measure designed to finance health insurance for the elderly through the payroll tax mechanism, especially under Social Security.

We respectfully urge that you promulgate and support efforts to allow Kerr-Mills through the several states to meet the medical needs of the elderly who cannot do so with their own resources.

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is a private psychiatric hospital established in 1925 for the treatment of nervous or mental disorders, alcohol or drug addiction problems.

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HILL CREST SANITARIUM *is a member of:*

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American Psychiatric Association
National Association of Private Psychiatric Hospitals
Alabama Hospital Association
Birmingham Regional Hospital Council

March of Dimes Program Enters 28th Year

The National Foundation for Infantile Paralysis observed its 27th birthday earlier this year and optimistically embarked on its 28th year of public service after announcing the establishment of more than 50 birth defects centers and clinics.

The foundation has celebrated the passing of many milestones since its incorporation Jan. 3, 1938, when then President Franklin Roosevelt announced the organization's aims as "to lead, direct and unify" the fight against polio. Basil O'Connor was the foundation's first president.

Since the organizational meeting and incorporation, the foundation has observed these milestones:

Jan. 3, 1938: The National Foundation for Infantile Paralysis incorporated. President Franklin D. Roosevelt states aims: "to lead, direct and unify" the fight against polio. Basil O'Connor named president.

May 12, 1939: First chapter started at Coshocton, Ohio.

April 16, 1940: First professional education grant authorized.

July 12-17, 1948: First International Poliomyelitis Conference (43 nations) held by March of Dimes in New York. Four other international polio conferences have been held in 1951, 1954, 1957 and 1960.

Jan. 28, 1949: March of Dimes-supported scientists (Dr. John Enders, Dr. Thomas Weller and Dr. Frederick Robbins of Harvard University) published first report of an historic research breakthrough by growing poliovirus in cultures of nonnervous tissue. For this, they received the Nobel Prize for medicine in 1954.

April, 1950: First March of Dimes-supported Respiratory Study Centers established at Houston and Boston.

Sept., 1951: Scientists in four laboratories supported by March of Dimes grants complete 2½-year project establishing three types of poliovirus responsible for disease.

Fall, 1951 and Summer, 1952: Human field trials on effectiveness of gamma globulin in preventing polio paralysis.

April, 1952: March of Dimes-aided scientists report discovery that antibodies in blood streams of monkeys prevent poliovirus from reaching vital nerve cells.

March 28, 1953: First medical report published on antipolio "killed-virus" vaccine developed by Dr. Jonas Salk under March of Dimes grant.

April 26, 1954: March of Dimes field trials for Salk vaccine began with 1,830,000 school children participating.

April 12, 1955: Salk vaccine pronounced safe, potent and effective.

July 22, 1958: The National Foundation expands its goals, announces it will use its resources to combat other major health problems, with arthritis and birth defects as initial new targets, in addition to polio.

Jan., 1960: First March of Dimes Birth Defects Clinical Study Center opened at Children's Hospital, Columbus, Ohio.

March 15, 1960: Announcement of the founding of The Salk Institute for Biological Studies at San Diego, Calif., with Dr. Jonas Salk as director, to be staffed by leading scientists from the United States and abroad.

July, 1960: Firt International Conference on Congenital Malformations, London, and Fifth International Conference on Poliomyelitis, Copenhagen, sponsored by The National Foundation-March of Dimes.

May 18, 1961: New expanded program of direct patient aid announced. Go-ahead given for nationwide network of chapter-financed Special Treatment Centers and Evaluation Clinics. Limitations lifted to include children suffering from all types of birth defects.

Jan., 1962: First Inter-American Conference on Congenital Defects held in Los Angeles, Calif., co-sponsored by the National Foundation and the University of California.

March, 1962: Public Health Service completes licensing action on oral vaccine developed by Dr. Albert R. Sabin. March of Dimes funds supported the research leading to development of the attenuated live-virus strains used in this second polio preventive.

Dec., 1962: The 1962 Nobel Prize in Medicine and Physiology shared by biophysicists Dr. F. H. C. Crick of Cambridge University, Dr. James D. Watson of Harvard and Dr. M. H. F. Wilkins of Kings College, London, for their discovery of the molecular structure of DNA, the substance of heredity. Dr. Watson was aided by a March of Dimes fellowship during the work for which the prize was given. Dr. Crick is a Visiting Fellow of The Salk Institute.

Jan. 3, 1963: 25th Anniversary of The National Foundation-March of Dimes, a quarter-century of medical-scientific progress encompassing the development of two vaccines to eliminate polio as a threat to public health, and the launching of an unprecedented attack on heretofore neglected birth defects and arthritis.

Jan., 1963: Third International Symposium on Immunopathology held in San Diego, Calif., co-sponsored by The National Foundation and the Atomic Energy Commission.

July, 1963: Second International Conference on Congenital Malformations sponsored by The National Foundation in New York; some 1,500 delegates registered from 21 nations.

Dec., 1963: Rapid expansion of Medical Care and Clinical Research Program indicated by number of March of Dimes Centers in operation—44 for birth defects; 25 for arthritis; 6 polio respiratory centers.

April, 1964: Conference of National Organizations in Los Angeles draws national officers of major women's organizations, representing more than 30 million U. S. members, for briefings on birth defects, arthritis, and visit to Salk Institute for Biological Studies.

Sept., 1964: The National Foundation cooperates with American Rheumatism Association and Arthritis and Rheumatism Foundation to form the new Arthritis Foundation of America as a unified, independent voluntary agency to combat crippling arthritis.

BUREAU OF PREVENTABLE DISEASES

W. H. Y. Smith, M. D., Director

CURRENT MORBIDITY STATISTICS

1965

	Jan.	Feb.	*E. E. Feb.
Tuberculosis	111	119	133
Syphilis	197	166	112
Gonorrhea	349	254	293
Chancroid	3	2	3
Typhoid fever	2	0	1
Undulant fever	0	0	0
Amebic dysentery	2	1	2
Scarlet fever & strep. throat	310	243	131
Diphtheria	0	2	1
Whooping cough	5	2	7
Meningitis	5	3	10
Tularemia	1	0	0
Tetanus	0	2	1
Poliomyelitis	0	0	0
Encephalitis	0	0	0
Smallpox	0	0	0
Measles	358	435	314
Chickenpox	156	124	158
Mumps	24	32	99
Infectious hepatitis	34	48	56
Typhus fever	0	0	0
Malaria	0	0	0
Cancer	479	587	607
Pellagra	0	2	0
Rheumatic fever	25	10	13
Rheumatic heart	27	31	32
Influenza	94	2,987	933
Pneumonia	277	361	326
Rabies—Human cases	0	0	0
Pos. animal heads	8	1	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

BUREAU OF LABORATORIES

Thomas S. Hosty, Ph.D., Director

February 1965

Examinations for intestinal parasites	1,223
Typhoid cultures (blood, feces, urine and other)	221
Examinations for malaria	3
Examinations for gonococci	1,787
Serologic tests for syphilis (blood and spinal fluid)	22,596
Darkfield examinations	3
Agglutination tests	5
Examinations for diphtheria bacilli and Vincent's	16
Complement Fixation	77
Examinations for Negri bodies (smears and animal inoculations)	217
Water examinations	2,065
Milk and dairy products examinations	3,744
Examinations for tubercle bacilli	3,797
Miscellaneous examinations	6,202
Total	41,956

*Dothan Branch Laboratory report was not received in time to be included in this report.



*a result of 'METHEDRINE'® brand METHAMPHETAMINE HYDROCHLORIDE therapy

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Side effects: Insomnia may occur if taken later than 6 hours before retiring. The usual peripheral actions of sympathomimetic amines (vasoconstriction and acceleration of the heart) are minimal and little noticed on low or moderate dosage.

Complete literature available on request from Professional Services Dept. PML

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Convention Calendar

MEDICAL ASSOCIATION OF THE STATE OF ALABAMA
(Annual Session)

April 22-24, Parliament House, Birmingham.

POSTGRADUATE COURSE IN 'CLINICAL GASTROENTEROLOGY'

April 22-24, St. Petersburg, Fla., sponsored by American Academy of General Practice, the Florida Institute for Continuing University Studies and The Mound Park Hospital Foundation. (18 accredited hours by the American Academy of General Practice.)

* * *

INTERNATIONAL COLLEGE OF SURGEONS

April 25-29, Las Vegas, Nev., North American Federation Congress.

* * *

AMERICAN COLLEGE OF PHYSICIANS

April 26-30, Humphreys Postgraduate Center, Denver, Colo., postgraduate course no. 13 Cardiopulmonary Diseases.

CONGRESS ON ENVIRONMENTAL HEALTH PROBLEMS

April 26-27, Drake Hotel, Chicago, sponsored by AMA, subjects include the application of medicine to the complex environment in which we live today. (Congress acceptable for 12 accredited hours by the American Academy of General Practice.)

HAHNEMANN MEDICAL COLLEGE AND HOSPITAL
(Postgraduate Education Course)

April 26-29, Sheraton Hotel, Philadelphia, course on Mechanisms and Therapy of Cardiac Arrhythmias, directed by Dr. Leonard S. Dreifus.

* * *

AMERICAN ACADEMY OF PEDIATRICS

April 26-29, Americana Hotel, Bal Harbour, Fla., spring meeting of the Pan-American Association.

* * *

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY
(Part II Oral And Clinical Examination)

April 26, May 1, Edgewater Beach Hotel, Chicago. New and reopened applications and requests for re-examination in the Part II examination for 1966 accepted in the office of the secretary, 100 Meadow Road, Buffalo, N. Y., during April and May, 1965.



"Relax, doctor, when you've performed this operation as often as I have, you learn to stride these things in your take."

(The New Physician)

FAMOUS ALABAMA PHYSICIANS

DR. CHARLES ADOLPH MOHR (1857-1949)—the first Professor of Pharmacy at the Medical College of Alabama—was born in Louisville, Kentucky, April 1, 1857. Later that year his parents moved to Mobile where his father established a drug store which he operated, exclusive of Civil War Years, until 1900.

Young Mohr was educated in the public schools of Mobile County. During this time, he learned pharmacy in his father's drug store where he received practical experience in compounding drugs as well as making extracts and decorations.

Later Mohr enrolled in the University of Cincinnati College of Pharmacy, graduating in 1878 where he was Number One in his class. He then entered the Medical College of Alabama and received his M. D. degree in 1884. Again he was Number One and delivered the Valedictory Address.

Apparently, Dr. Mohr taught as well as studied during these years. The Medical College of Alabama Catalogue for 1880 lists him as Assistant Professor of Chemistry along with nine other faculty members. In 1885 he was named Professor of Chemistry and Lecturer on Practical Pharmacy. Dr. Mohr was to remain a faculty member at the Medical College through the year 1919.

Although Dr. Mohr received his M. D. degree in 1884, he was so occupied with his teaching activities that he delayed for several years taking the examination for a license to practice medicine. His license was dated December 5, 1892. He scored an average grade of 95.77 and made a grade of 100 on each of three subjects.

In 1903 Dr. Mohr opened an office for the practice of medicine. This he combined with his teaching schedule, also finding time to serve as secretary and treasurer of the Medical College Athletic Board.

In 1911, Dr. Mohr added to his duties the office of chairman of the Board of Health of Mobile. When the Mobile city and county health offices were combined a few years later, Dr. Mohr became County Health Officer and held the position until 1934.



Dr. Mohr was active in medical societies, serving as secretary of the Mobile society and later president of that organization. He was elected a life counsellor of The Medical Association of the State of Alabama in 1909 and was a member of the State Board of Censors from 1915-1920. In 1926, Dr. Mohr was elected president of the state association.

In 1931, Dr. Mohr was elected a member of the Board of Trustees of Alabama State Hospitals and served until his death November 28, 1949, at the age of 92. He attended a meeting of the Board of Trustees at Searcy Hospital in Mount Vernon the day before his death.

The minutes of the Board of Trustees of the Alabama State Hospitals and the Partlow State School carried the following after Dr. Mohr's death:

" . . . this great clarity of mind, coupled with a good sense of humor, kept him in step with the great march of time. He was never outmoded. His advice continued to be sought by fellow-members of the Mobile County Medical Society. He was a man of determination with a sense of responsibility."

His residence at 254 St. Anthony Street in Mobile now houses the American Red Cross.

One of a series of Famous Alabama Physicians based on research compiled by Dr. E. B. Carmichael for

Durr Surgical Supply Co.
Montgomery —— Birmingham —— Huntsville

AMERICAN COLLEGE OF SURGEONS
(Chicago Committee on Trauma)

April 28-May 1, John B. Murphy Memorial Auditorium, Chicago, sponsored by American College of Surgeons featuring eight lectures by Jorg Bohler, renowned orthopaedic surgeon who is professor of accident surgery, University of Vienna, program also to include lectures by American surgeons of renown, registration to Dr. John J. Fahey, 1791 Howard St., Chicago, Ill., 60626.

* * *

MEDICAL COLLEGE OF GEORGIA

May 1-2, Augusta, Ga., seminar on Chronic Obstructive Lung Disease.

* * *

NATIONAL LEAGUE OF NURSING

May 3-7, Civic Auditorium, San Francisco, Cal., annual convention.

AMERICAN COLLEGE OF PHYSICIANS

May 10-14, New York University Medical Center, New York, N. Y., Postgraduate Course No. 14, Rehabilitation, Howard A. Rusk, M. D., director.

* * *

AMERICAN COLLEGE OF PHYSICIANS

May 24-26, Royal Victoria Hospital, Montreal, Canada, Postgraduate Course No. 15, Current Concepts In Gastroenterology, Richard D. McKenna, M. D., director.

* * *

CHILDREN'S HOSPITAL OF PHILADELPHIA

May 24-28, Philadelphia, Pa., Five-Day Refresher Course in Pediatrics, curriculum consisting of lectures and clinics by members of the faculty staff.



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The Woman's Auxiliary



Dear Doctors:

This is my farewell letter to you. I am going to miss thinking up the most important thing to tell you and the frantic calls from the editorial staff of The Journal of the Medical Association of the State of Alabama begging me to please have the muse strike so they will get the copy on time. Nell Williford told me that they keep a file of my letters and all were anxious to read the latest one to see what my excuse was for being late. Let me tell you, I thought up some good ones.

I need to give you a report on the auxiliary year so you will know how much we have done but our state reports are just being made out (this column is written during the first week of March), and I haven't seen any of them yet. I do know that all of the auxiliaries that I visited were working hard and I found out something else, they do more work than they write down on their reports. I wish you would ask them to report to your county medical societies so that you would be informed on all of their activities instead of just hearing the problems your own auxiliary member wife is having with the project in which she is involved. Not only would you know how much work they do, you might have suggestions for them concerning a project that meets a particular need in your county. I have said frequently that the national and state auxiliaries are like the Southern Baptist Church, we've got programs to cover nearly every need you face. The only difference is that we don't have to be standard. We try to concentrate on what needs to be done to meet local needs.

I do have a few things to report that I have picked up on my visits to the local auxiliaries. 9,000 school children, residents of Cullman County, carried home the safety questionnaire that I had in my column last month. I've already had some repercussions among my friends, they are calling me and asking if I don't want to come over and rearrange all dangerous materials kept in the kitchen, the laundry, the garage, and in the bathroom.

I know that many auxiliary members worked hard in the political campaign last year. They are interested citizens and pulling their share of the load to help make Alabama a better place to live. I also know that they are going to work on the Eldercare program.

Your wives have been busy raising money for AMAERF but don't know what the final total amount will be yet. I do know that I have not visited a county auxiliary that has not equaled the amount they raised last year and many of them are sending in more money than they have ever raised before.

We are still trying to interest young people in following a profession connected with Health Careers. All of this hard work means that three or four years from now technicians, nurses, record librarians, etc., will be available in greater numbers. Of course, the population explosion may make us feel that we are not any better off than we were before.

On the International Health front, boxes and boxes of drug samples and many yards of bandages have been sent to World Medical Relief. I'd almost bet that there is not a single tired sheet left in Alabama.

Project after project could be listed, but you might get bored and the auxiliary would overflow its allotted space.

Bring your wife to the state convention April 22, 23, 1965. Send her to the auxiliary meetings. It will save you money and she will get educated.

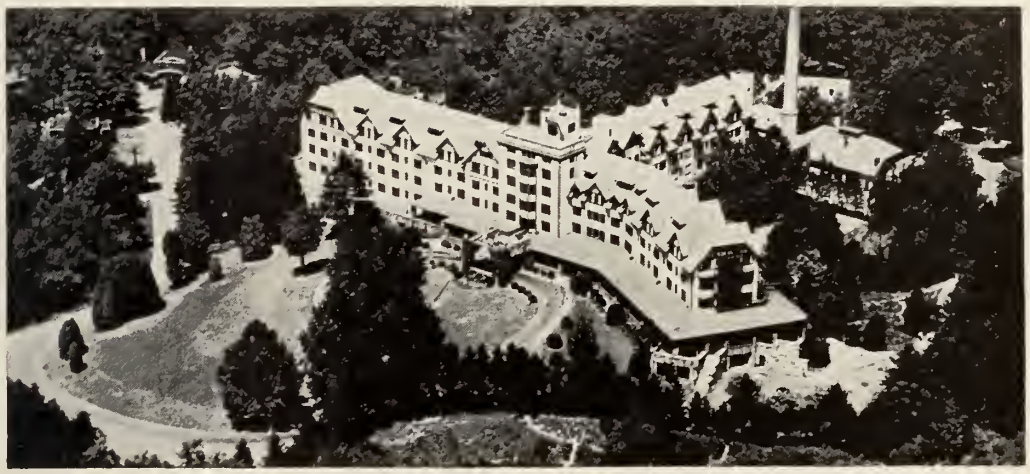
See you in Birmingham,

Frances Clemmons

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Wm. Ray Griffin, Jr., M. D.
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Mark A. Griffin, Sr., M. D.
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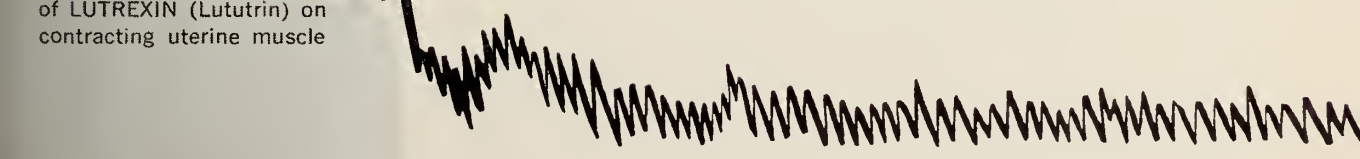
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Arteries now have no place to hide

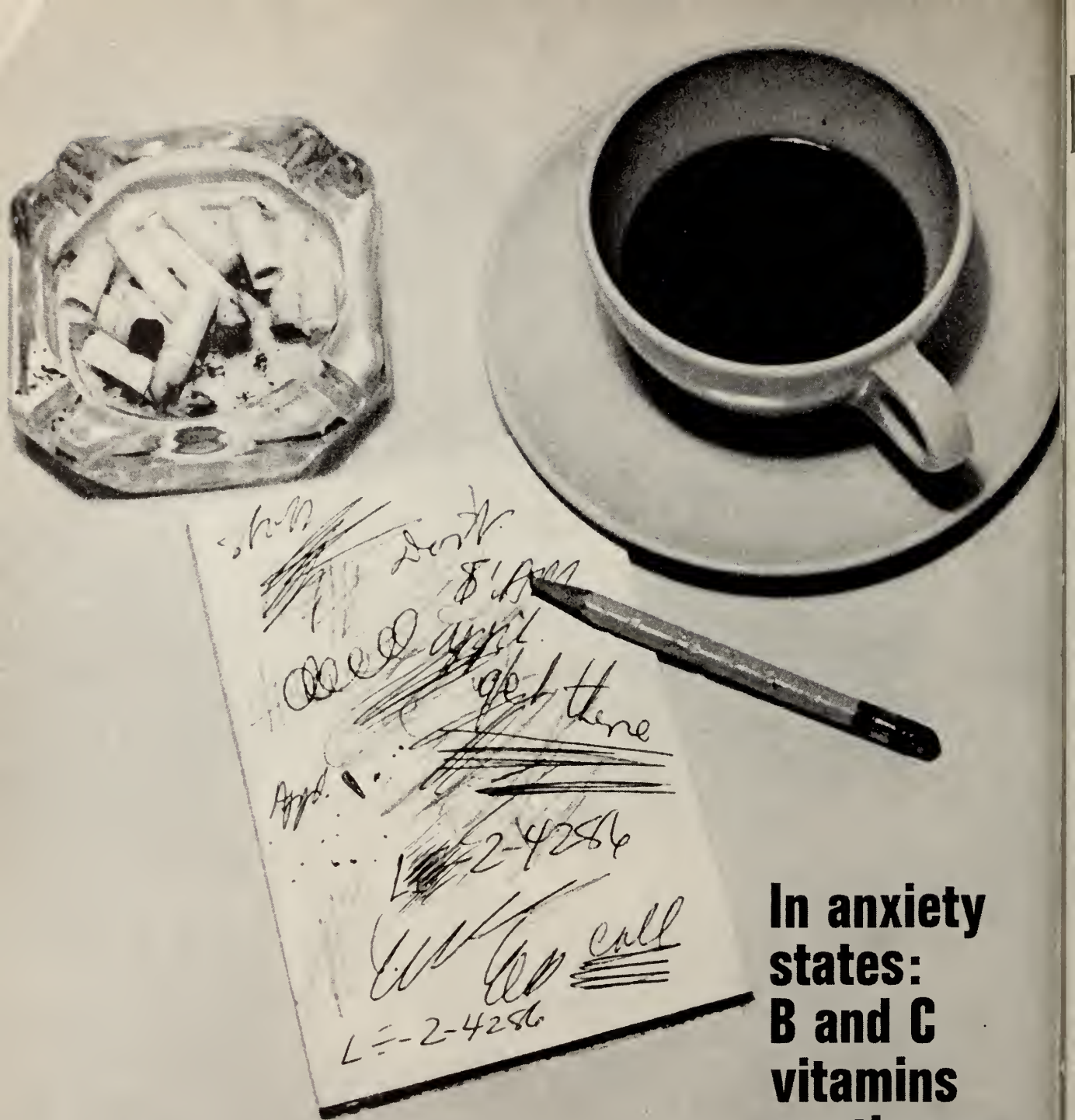
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President's Page

On April 8th, 1965, the House of Representatives of the Congress of the United States, by a majority of almost 3 to 1, passed an omnibus "Medicare" bill. If this bill passes the Senate, for the first time in American history a compulsory payroll tax would be levied to provide significant health service in the form of hospitalization for a large segment of our population. Health service provided by compulsory payroll tax is certainly a form of socialized medicine, even though professional fees are not involved in this particular mechanism at the present time.

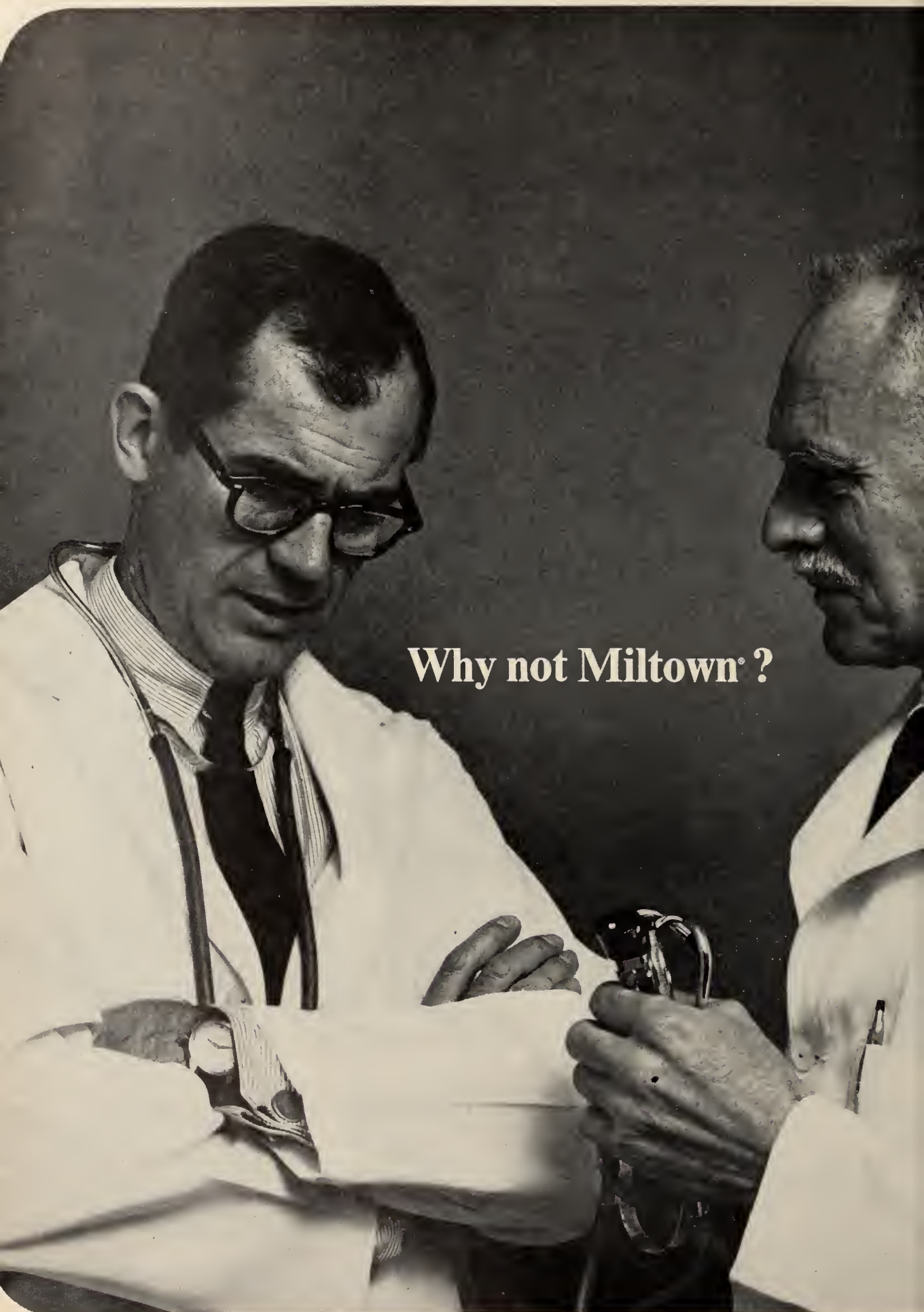
The Eldercare proposal of the American Medical Association to provide federal subsidy to help pay private insurance premiums for health care of the needy aged was never given a chance. The Administration, with the complete cooperation of Rep. Wilbur Mills, Chairman of the House Ways and Means Committee, grabbed the more comprehensive health care features of the American Medical Association plan and mixed them with its own socialistic program mentioned above. This was rushed through the House Ways and Means Committee without open hearings and was rushed through the House of Representatives under a closed rule which limited debate and amendment.

Profound changes in health care will result if this bill is passed by the Senate. A recent article, referring to the Federal aid programs already in existence in the health field, raised the question, "How will we know when we have Socialized Medicine?" The dividing line between Federal aid and Federal control of professional care will finally be crossed by this legislation. Many hospitals in Alabama have recently witnessed the exercise of Federal power to control their traditions and internal operations. This has been applied by economic threat which, unfortunately, has great force due to Federal involvement in the economy of hospitalization already in existence. Under this new legislation the Federal government would pay for medical, as well as hospital costs, for millions of Americans. Because of this, the Federal government will judge and control both quality and cost of medical and hospital care. This will take the form of utilization committees, fee schedules which can be "adjusted" by the Federal government at will, review committees, control of hospital policies and costs, quality of treatment, length of stay, etc. These power controls will not be fully applied at first, and many doctors may be lulled into a sense of satisfaction with the program just as the American Hospital Association has been. However, the controls are written into the bill and will be applied as needed.

The AHA is attempting to have the Senate include pathologists, radiologists and anesthesiologists in the permanent Medicare bill.

Only a miracle can keep this bill from passing the Senate. A similar proposal passed the Senate last year, but was killed in the House. The Senate has an even greater liberal majority now. However, Sen. Harry F. Byrd, Chairman of the Finance Committee, has promised open hearings on the bill. Every doctor should use all the influence he can bring to bear upon any Senator to amend the bill to drop the compulsory payroll tax to finance any segment of health care and to substitute one of the proposals similar to the American Medical Association's Eldercare plan. It is to the credit of Alabama that seven of our eight Representatives voted against this socialistic medical bill; the eighth, Rep. Bob Jones, voted for it. Senator Lister Hill and Senator John Sparkman are very influential senior Senators. They have consistently voted against this type of legislation in the past and it is to be hoped that they will not only vote, but work for modification of the socialistic features of this bill. None of us are against governmental help with health costs of needy people to whatever extent is necessary. However, universal payroll tax to support any nation-wide health service under control of the Federal government is socialized medicine and should be vigorously opposed.

James G. Donald, M. D.


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An Analysis Of Twelve Year Experience Of Gastric Resections–1950-1962– At Carraway Methodist Hospital

Ben M. Carraway, M. D., F. A. C. S.

James E. Gaba, M. D.

Birmingham, Alabama

The literature is graced with many classic monograms relating to gastric resections and diseases attacking the duodenum and the stomach. One hesitates to add new ones as it seems the subject has been investigated and analyzed as thoroughly as possible. However, when the cases at Carraway Methodist Hospital, a 316 bed community hospital in Birmingham, Alabama, were analyzed it was found that a significant difference exists between the number of patients treated surgically for duodenal ulcer than the national average. It was deemed feasible to analyze the entire series for a twelve year period of all gastric resections at this institution, as it may reveal a useful reference. The purpose of this paper is to adequately evaluate and correlate the experiences of gastric resections for those surgical diseases attacking the stomach and duodenum at this hospital for a 12 year period; as it was felt that an adequate follow-up could be obtained which would be useful for a 12 year period.

Materials and Methods

The patients charts, questionnaire by mail and personal interview were utilized entirely in the preparation of this paper for the source of material. The methods utilized were by an analysis of each record for the patient involved and when the record was incomplete a questionnaire was mailed to the patient. The questionnaire consisted of a postal card with the following related questions: 1. Have you gained or lost weight since your operation? 2. Can you eat anything you want? 3. Do you have weak or dizzy spells since your operation? 4. Have you had nervous spells since your operation? 5. Have you used tobacco in any form regularly? 6. Have you used alcohol in any beverage form regularly? (This will not show on your record). 7. Are you glad you had your operation? 8. If the patient is not living, please show date and cause of death, if known. One hundred and fifty-eight cards were mailed, 93 charts were adequately written for follow-up and 28 patients failed to respond and their charts were evaluated as to the last date seen. The inquiries made on the postal cards were very generalized in order to avoid suggestion of symptoms or arousal of suspicion in the patient but seeking, appropriately as possible, information concerning weight, dumping, psychiatric disorders, effect of tobacco, and alcohol. The patient is then given the opportunity to voice his criticism of his surgery by

indicating pleasure or displeasure. The family was given the opportunity to comment on the results of the patient's surgery if the patient were deceased, and of those that were, many did so.

Analysis of Cases

Table I lists the total number of patients admitted to the hospital for the 12 year period and the number with duodenal ulcer, gastric ulcer, and carcinoma of the stomach. We find that three per cent of the patients with duodenal ulcer were treated surgically, while the national average treated surgically[3] is 20 per cent. Seventy-three per cent of the patients with gastric ulcer were treated surgically, while the national average is 40 to 50 per cent.[11] All of the patients with carcinoma were deemed operable and were treated surgically which concurs with other reports.[12] The patients were then divided into sex and race (Table II) and there are 77 per cent males and 23 per cent females and is comparable to a recent monograph.[9] The ages of all patients were tabulated and the average age was found to be 48 years with the females slightly older than the males (Table III). This was further broken down into sex and race. The occupations (Table IV) of the patients were considered and the laboring class was found to constitute about one-half, while the professional group constituted less than one-tenth of the patients. The significance of this analysis is in the preponderance of miners and millworkers treated at this hospital during this period. The majority of the professional people were ministers because of the association of the hospital with the church. The presenting complaints are tabulated in Table V. We find that many of the patients had one or more of the presenting complaints. Intractability, hemorrhage and obstruction were the chief indications for surgery while hemorrhage, obstruction and perforation were indications in a similar[7] analysis. Also, listed in Table V is significant past history, such as previous perforation requiring closure 6 per cent, previous gastroenterostomy 2 per cent, previous antrectomy and vagotomy 0.5 per cent, and previous pyloroplasty 0.5 per cent. In Table VI the findings at operation are listed as several patients had more than one finding. They are listed under the one producing the symptoms over a longer period of time when it was possible to classify it in this manner. Over one-half of the patients had pyloric narrowing due to scarring from chronic ulcer disease. One interesting statistic was one patient with carcinoma of the stomach, as she had a previous unrelated carcinoma of the breast treated by radical mastectomy two years previously. The mortality rate of each disease is listed in Table VII. The mortality rate for duodenal ulcer is less than the national average[2] and when the mortality rate for the duodenal and gastric ulcer are combined the rate is comparable. The mortality rate for carcinomas treated surgically was listed in this manner as many of the patients expired less than one year after discharge from the hospital and the length of time they lived could not be determined. However, the operative mortal-

TABLE I

Number of patients treated	5,281	(100%)
Patients with duodenal ulcer	5,191	(98%)
Patients with gastric ulcer	63	(1%)
Patients with carcinoma	27	(0.5%)
Number requiring surgery	222	(4%)
Number treated medically	5,059	(96%)
Patients with duodenal ulcer treated surgically	149	(3%)
Patients with gastric ulcer treated surgically	46	(73%)
Patients with carcinoma treated surgically	27	(100%)

TABLE II

Number of male patients treated surgically	171	(77%)
Number of female patients treated surgically	51	(23%)
Number of White males	154	(69%)
Number of White females	44	(20%)
Number of Negro males	19	(9%)
Number of Negro females	5	(2%)

TABLE III

Average age of all patients	48 years
Average age of males	49 years
Average age of females	51 years
Average age of White males	46 years
Average age of White females	50 years
Average age of Negro males	52 years
Average age of Negro females	53 years

TABLE IV
OCCUPATION

Laborer	102	(46%)
White collar	60	(27%)
Housewife	42	(19%)
Professional	9	(5%)
Unemployed	10	(3%)

TABLE V
PRESENTING COMPLAINTS

Weight Loss	13	(6%)
Intractable Pain	162	(73%)
Vomiting	21	(10%)
Hematemesis-Melena	45	(20%)
Diarrhea	2	(1%)
Gunshot Wound	1	(0.5%)
Findings during incidental x-ray examination	5	(2%)
Incidental finding during hysterectomy	1	(0.5%)

*Several patients had one or more complaints

SIGNIFICANT PAST HISTORY

Previous Perforations of duodenal ulcer requiring surgery	13	(6%)
Previous Gastroenterostomies	5	(2%)
Previous Antrectomy and Vagotomy	1	(0.5%)
Previous Pyloroplasty	1	(0.5%)

TABLE VI
FINDINGS AT OPERATION*

Pyloric narrowing due to chronic ulcer disease	111	(50%)
Penetrating duodenal ulcer	40	(18%)
Acute perforated duodenal ulcer	4	(2%)
Carcinoma of the duodenum	1	(0.5%)
Gastric ulcers	41	(19%)
Gastric hemorrhage	10	(5%)
Gastrocolic fistula	1	(0.5%)
Carcinoma of the stomach	27	(12%)
Carcinoma of the stomach preceded by two years of an unrelated carcinoma of the breast treated by radical mastectomy	1	(0.5%)

*Several patients had multiple findings and are classified in the overall analysis as duodenal ulcer, gastric ulcer or gastric carcinoma.

TABLE VII

Mortality rate of duodenal ulcers treated surgically	1%
Mortality rate of gastric ulcers treated surgically	4%
Mortality rate of carcinomas treated surgically	81%*

*Died of carcinoma two days to 10 years.

ity for the immediate postoperative period was comparable with the national average of 8.2 per cent.[12]

The patients with duodenal ulcer disease treated surgically are evaluated in Table VIII. They constitute 67 per cent of the total

TABLE VIII
ANALYSIS OF DUODENAL ULCERS TREATED SURGICALLY—149 (67%)

Average age	49 years
Males	121 (81%)
Females	28 (19%)
White Males	113 (76%)
Age Range	20-72 years
Average Age	46 years
White Females	25 (17%)
Age Range	31-66 years
Average Age	48 years
Negro Males	8 (5%)
Age Range	27-70 years
Average Age	50 years
Negro Females	3 (2%)
Age Range	49-55 years
Average Age	52 years
RESULTS:	
Excellent to good	134 (90%)
Unsatisfactory	15 (10%)
2/3 Gastrectomy Billroth I anastomosis	34 (23%)
Excellent to good results	30 (88%)
Unsatisfactory results	4 (12%)
2/3 Gastrectomy Billroth II Hofmeister anastomosis	84 (56%)
Excellent to good results	76 (91%)
Unsatisfactory results	8 (9%)
2/3 Gastrectomy Billroth II Polya anastomosis	25 (17%)
Excellent to good results	23 (92%)
Unsatisfactory results	2 (8%)
2/3 Gastrectomy and bilateral vagotomy Billroth I or Billroth II anastomosis	6 (4%)
Excellent to good results	5 (83%)
Unsatisfactory results	1 (17%)
2/3 Gastrectomy requiring Foley catheter duodenostomy Billroth II anastomosis	5 (3%)
Excellent to good results	5 (100%)
Marginal ulcers	4%
Dumping syndrome	4%
Chronic dumpers (more than 6 years)	1%
Operative mortality	1%
Patients with duodenal ulcers treated surgically now deceased	7 (5%)
Died of cirrhosis 8 years postoperatively	1
Died of coronary thrombosis 6 years postoperatively	3
Died during surgery for cholecystectomy 7 years postoperatively	1
Died of fractured hip complications 8 years postoperatively	1
Died of pancreatitis 7 days postoperatively	1

number treated surgically, 81 per cent males and 19 per cent females with an average of 49 years. The group is then broken down into sex, race, age range and the average age for each group. In each of the patients operated for duodenal ulcer disease a 2/3 gastrectomy with Billroth I, Billroth II Hofmeister anticolic, Billroth II Polya anticolic anastomosis and 2/3 gastrectomy and bilateral vagotomy with Billroth I or Billroth II anastomosis were utilized. In five patients undergoing 2/3 gastrectomy with Billroth II anticolic anastomosis, the duodenal stump could not be closed and a Foley catheter duodenostomy was utilized. Ninety per cent of the patients have been found to have excellent to good results and 10 per cent an unsatisfactory result. This was further classified as to type of anastomosis and result. The best result was after a 2/3 gastrectomy and Billroth II Hofmeister anticolic anastomosis. The most unsatisfactory results were in those undergoing a 2/3 gastrectomy and a Billroth I anastomosis. This is comparable to other[1,2,3,4,7,8] reports. The 10 per cent unsatisfactory results are four per cent marginal ulcer, four per cent dumping, one per cent chronic dumping and one per cent operative mortality. The operative mortality was a 30 year old white male who underwent a 2/3 gastrectomy with a Billroth II anticolic anastomosis for intractable duodenal ulcer disease and developed acute pancreatitis and expired on the seventh postoperative day. The other patients undergoing gastrectomy, who are now dead but are not an operative mortality, are listed in Table VIII. In this group of patients with duodenal ulcer disease treated surgically only one other will be briefly mentioned. This patient is a 40 year old unemployed white male presenting with epigastric pain to the left of the umbilicus, associated with melena, bright red bleeding and diarrhea. The patient had had 57 operations for surgery related to the genitourinary system since the age of 14 years for traumatic transection of the urethra, and it was during one of these admissions that he hemorrhaged from his stomach and emergency surgery was required to find the source of the bleeding. At surgery a duodenal ulcer on the posterior superior portion of the duodenum against the pancreatico-duodenal vessels with perforation into the pancreas was found, along with marked scarring and narrowing of the pylorus. The ulcer was adequately resected and a 2/3 gastric resection with enough mobilization of the duodenum to do a Billroth I anastomosis was done. Three years later the patient developed a bleeding marginal ulcer but had since undergone two more major surgical procedures for the urinary tract and he responded to medical treatment for his ulcer. For the past two years he had homologous serum jaundice intermittently. In December of 1964 he expired from liver failure and at post-mortem examination the gastroduodenostomy was found to be adequate without ulcer disease. This patient was mentioned as he was subjected to considerable stress for many years because of his genitourinary disease and emergency surgery was required to control the hemorrhage. Ulcer disease of long standing was found and the duodenum could be mobilized enough to allow adequate resection of the ulcer and a gastroduodenostomy adequately done. However, this points out the high recurrence rate of marginal ulcer in Billroth I anastomosis, as this patient developed. This type of marginal ulcer will respond to medical therapy better than those that develop following a gastroenterostomy as Dr. Lahey pointed out in an article in 1941.[1]

In Table IX the patients undergoing gastrectomy for gastric ulcers are analyzed. Twenty-one per cent of the total number of patients operated on fall into this group. The average of 52 years with 72 per cent males and 28 per cent females is comparable to other reports.[5,7] Eighty-three per cent good results and 17 per cent unsatisfactory results. They were divided into type of gastrectomy with type of anastomotic reconstruction. The best results were in those undergoing a 2/3 gastrectomy and a Billroth I anastomosis with 94 per cent excellent results and six per cent unsatisfactory results. The operative

TABLE IX

ANALYSIS OF GASTRIC ULCERS TREATED SURGICALLY—46 (21%)

Average Age	52 years
Males	33 (72%)
Females	13 (28%)
White Males	27 (59%)
Age range	31-73 years
Average age	52 years
White Females	12 (26%)
Age range	27-72 years
Average age	56 years
Negro Males	6 (13%)
Age range	27-67 years
Average age	48 years
Negro Females	1 (1%)
Age range	51 years
Average age	51 years

RESULTS

Excellent to Good	38 (83%)
Unsatisfactory	8 (17%)
2/3 Gastrectomy Billroth I Anastomosis	17 (37%)
Excellent to Good results	16 (94%)
Unsatisfactory results	1 (6%)
2/3 Gastrectomy Billroth II Hofmeister Anastomosis	24 (52%)
Excellent to Good results	18 (75%)
Unsatisfactory results	6 (25%)
2/3 Gastrectomy Billroth II Polya Anastomosis	5 (11%)
Excellent to Good results	4 (80%)
Unsatisfactory results	1 (20%)
2/3 Gastrectomy and bilateral vagotomy* Billroth I or Billroth II anastomosis	3 (7%)*
Excellent to Good results	3 (100%)

*Included in total analysis preceding.

Operative Mortality	4%
Patients requiring surgery for gastric ulcers now deceased	3 (7%)
Anemia and malnutrition deceased 3 years postoperatively	1 (33 1/3%)
Cerebral Thrombosis deceased 4th postoperative day	1 (33 1/3%)
2/3 gastrectomy Billroth II anastomosis, developed gastrojejunal fistula 24th postoperative day; T tube inserted into jejunum direct vision 35th postoperative day; fistula resected 45th postoperative day and colonic fistula closed; expired 50th postoperative day	1 (33 1/3%)

mortality of four per cent is slightly better than 5.7 per cent mentioned as a comparative mortality figure for gastrectomy.[2] The patients undergoing gastrectomy for gastric ulcers now deceased are analyzed in Table IX. None of the patients in this analysis was found to have a high lying gastric ulcer in which a wedge resection of the ulcer could be done as reported by one author.[9]

TABLE X

ANALYSIS OF GASTRIC CARCINOMAS TREATED SURGICALLY—27 (12%)

Average age	57 years
Males	19 (70%)
Females	8 (30%)
White Males	15 (56%)
Age range	23-85 years
Average age	60 years
White Females	5 (18%)
Age range	40-73 years
Average age	52 years
Negro Males	4 (15%)
Age range	55-67 years
Average age	62 years
Negro Females	3 (11%)
Age range	49-59 years
Average age	54 years

RESULTS

Excellent to Good	5 (19%)
Unsatisfactory	22 (81%)

*Patients deceased of carcinoma at time of analysis considered unsatisfactory.

3/4 Gastrectomy Billroth I Anastomosis	2 (7%)
3/4 Gastrectomy Billroth II Hofmeister Anastomosis	8 (30%)
2/3 Gastrectomy Billroth I Anastomosis	8 (30%)
2/3 Gastrectomy* Billroth II Hofmeister Anastomosis	5 (18%)
4/5 Gastrectomy Billroth I Anastomosis	1 (4%)
Total Gastrectomy Esophagojejunal Anastomosis	3 (11%)
Total patients operated upon for gastric carcinoma now deceased 1-10 years postoperatively	22 (81%)
Number died of carcinoma	21
Number died of other causes	1
Total patients operated upon for gastric carcinoma now living	5 (19%)
Living 8 years postoperatively	1 (20%)
Living 4 years postoperatively	2 (40%)
Living 3 years postoperatively	1 (20%)
Living 2 years postoperatively	1 (20%)

The patients with carcinoma of the stomach are analyzed in Table X. We find that 27 or 12 per cent of the total number of pa-

TABLE XI

1	Patient (a 71 year old white female) had carcinoma duodenum; underwent resection 1st and 2nd part duodenum with tumor mass and ¾ gastrectomy Billroth II Polya anastomosis; died less than 1 year postoperatively of metastatic carcinoma.
5	Patients were found to have duodenal and gastric ulcers and 2/3 gastrectomy done Billroth II Hofmeister anastomosis with 100% excellent to good results.
1	Patient had a gasthojejunocolic fistula which was resected, closed and reanastomosed Billroth I with excellent to good results.

tients requiring surgery fall into this group. The average of 57 years is greater than that of reported gastric ulcers and duodenal ulcers. Seventy per cent male and 30 per cent female is the same as that of those operated upon for gastric ulcers. There are about 10 per cent more females in this group than that of the duodenal ulcer group. The results are listed as good, if the patient is still living at the time of the analysis, and unsatisfactory if the patient is deceased at the time of the analysis. This was done in this way because of the patients that had expired since surgery, the majority could not be traced to analyze the per cent of postoperative yearly survival. One patient was most interesting that is placed in this group. This is an eighty-five year old white male, retired minister who underwent a 4/5 gastric resection with a Billroth II Polya anticolic anastomosis. He did well for ten years and sustained a hip fracture ten years postoperatively, and withstood a surgical correction. He was returned to his nursing home where he expired approximately three months later of an unrelated pneumonia. One author[12] mentions a radical partial resection of the stomach with removal of the spleen, lymphnodes and omentum as the most satisfactory method of treatment. Another author[13] mentions each case must be individualized and all of the palpable carcinoma removed. In one of the cases operated here was the spleen removed and a radical lymphnode dissection done. It was felt that these cases were individualized as they presented themselves. In Table X the type of operation is listed and also listed are the patients living postoperatively. We find that five or 19 per cent of the patients operated on for gastric carcinoma are now living eight years postoperatively.

In Table XI three miscellaneous conditions are noted. One, a 71 year old white female, underwent a 3/4 gastrectomy and resection of the first and second part of the duodenum with a tumor mass involving same, and a Billroth II Polya anticolic reconstruction was done. The patient died less than one year postoperatively of metastatic carcinoma. Five patients were found to have duodenal and gastric ulcers and they underwent a 2/3 gastrectomy, Billroth II Hofmeister anticolic anastomosis with 100 per cent excellent to good results. One patient had a gastrojejunal colic fistula which was resected, closed and reanastomosed and a Billroth I reconstruction with excellent to good results.

In Table XII the patients corresponded with are analyzed. We find that 71 per cent were questioned and 64 per cent of the questionnaires were returned. Of the returned questionnaires seven per cent were uncompleted, 57 per cent were fully completed and six per cent stated that the patient had deceased. In 64 per cent of the patients their weight was either unchanged or gained and 36 per cent had lost weight. To adequately evaluate the weight of the individual patient, many factors would have to be analyzed, as many of the patients were obese prior to surgery. Those underweight prior to surgery due to obstruction have regained their normal weight since surgery. Several of the patients require intensive psychiatric care and in others minor emotional factors affect their weight gain.[4] The figures reported in this series are certainly at variance with those reporting a distal antrectomy (25 per cent or less) and complete vagectomy,[5,6] as they report a 94 per cent weight gain, six per cent unchanged and 0 per cent lost. Seventy-eight per cent of the patients in our series were able to eat anything desired and 22 per cent were unable to eat anything desired. The group[6] reporting distal antrectomy and complete vagectomy report that 100 per cent of

their patients have no trouble with any kind of meals. Fifty-one per cent of the patients report weakness and dizziness at various times and 49 per cent deny this occurrence. Whether this represents actual dumping could not be accurately stated. The Medical Department at our institution felt this question should be asked in such a manner as to be obscure or disguised enough so dumping could not be suggested to the patient. When the patients were evaluated medically and radiologically, only four per cent were found to be suffering from the dumping syndrome, and one per cent was found to be chronic dumpers. In a similar type of analysis[9] 5.8 per cent dumping is noted. Fifty-three per cent of the patients suffer from nervousness at one time or another and 47 per cent have no trouble with this problem. Whether or not this and the use of tobacco and alcoholic beverages substantially affect the overall results remains to be seen. Ninety-seven per cent of the patients stated they were pleased with the result of their surgery and only three per cent were not pleased. In a similar study[4] 90 per cent of the patients reported their results good, five per cent fair and five per cent poor. The result is gratifying when one wonders if the fruits of his labor is beneficial when three per cent of those who expressed displeasure and found to have unsatisfactory results appear with increasing frequency to bemoan their dissatisfaction. When one considers that 67 per cent of the patients undergoing surgery fall into the duodenal ulcer group, which comprises only three per cent of the total patients with the disease, are finally operated upon, the findings at operation would certainly be more profound and the morbidity greater because of the length of time the patient has lived with his disease undergoing medical therapy. It must also be surmised that a great number of these patients are either being treated or have been treated surgically at other institutions or became alimentary cripples or died from other causes with their ulcer disease unresolved.

TABLE XII

Analysis of patients corresponded with	158	(71%)
Number of cards returned	101	(64%)
Number returned uncompleted	11	(7%)
Number returned fully completed	90	(57%)
Number returned stating patient deceased	10	(6%)
WEIGHT		
Unchanged	26	(28%)
Gained	32	(36%)
Lost	32	(36%)
ABILITY TO EAT ANYTHING DESIRED		
Able	70	(78%)
Unable	20	(22%)
SUFFER FROM WEAK AND DIZZY SPELLS:		
YES	46	(51%)
NO	44	(49%)
SUFFER NERVOUSNESS:		
YES	48	(53%)
NO	42	(47%)
CONTINUE TO USE TOBACCO IN ANY FORM:		
YES	57	(63%)
NO	33	(47%)
CONSUME ALCOHOLIC BEVERAGES REGULARLY:		
YES	21	(24%)
NO	69	(76%)
PLEASED WITH RESULTS OF SURGERY:		
YES	87	(97%)
NO	3	(3%)

TABLE XIII
YEARS FOLLOWED

2	36
3	25
4	9
5	14
6	13
7	11
8	10
9	10
10	11
11	15
12	5
13	14
AVERAGE NUMBER YEARS FOLLOWED	6 years

Discussion

The most frequent type of surgery for peptic ulcer disease has ranged from gastroenterostomy to 85 per cent gastric resection with gastroenterostomy to distal antrectomy (25 per cent or less) with Polya anastomosis associated with complete vagectomy bilaterally. In 1941 Dr. Frank H. Lahey[1] discussed the phase the pendulum had swung through at that time. He stated that it was felt by many very good surgeons that gastroenterostomy was the answer to all peptic ulcer

disease and no peptic ulcer should be treated by medical means. In a very short period of time it became apparent that 16 to 18 per cent or greater developed marginal ulcers which were very resistant to medical therapy and would perforate with frequency (11 per cent) into the transverse colon. He would only use this procedure at that time of his series in poor risk patients with very low acid. Pyloroplasty was mentioned but too many recurrences resulted. Gastroduodenostomy was fraught with stomal ulcers which frequently recurred, and the only cure was adequate resection that required obliteration of the common duct. The Billroth I resection was considered to be one of the safest, but as too much stomach was left, in order to get a good anastomosis the recurrence rate of marginal ulcers was extremely high. It had been nearly abandoned by his group. The Billroth II, Polya and Hofmeister were the most satisfactory type of reconstruction with the Hofmeister being the most frequently used. An anticolic anastomosis was most frequently used because obstruction was too great in the retrocolic anastomosis. Of patients with duodenal ulcer disease treated at our institution, there is considerable variance of those treated surgically as compared to other institutions.[2,3] Three per cent of our patients were treated surgically and 97 per cent were treated medically. Because other groups[2,3] have a 20 to 30 per cent operative rate certainly would indicate that the patients treated at this institution were absolute surgical indications. It would also indicate that a significant percentage of this group was treated surgically at other institutions or became alimentary cripples or died with their disease unresolved from other causes. The average age of 49 years, with 81 per cent males and 19 per cent females, is similar to other groups.[4] The presenting complaints, intractable pain, bleeding, obstruction and recurrent ulcer, were similar to those of other reports.[5,6,7] Two-thirds gastric resection with Billroth II anticolic Hofmeister, Polya, Billroth I and vagotomy are similar to other recent monographs[8] in the literature. Our results were 90 per cent good and 10 per cent unsatisfactory. One per cent chronic dumpers, four per cent marginal ulcers and operative mortality of one per cent was very similar to a series[2] reported in 1945, in which the patients underwent a 2/3 gastric resection with a Polya anastomosis and a three per cent mortality rate, eight per cent recurrent ulcer and 90 per cent good results. Another recent[9] report prefers a Billroth II Hofmeister anticolic anastomosis for duodenal ulcers and has a 15 per cent marginal occurrence, 5.8 per cent dumping and a six per cent mortality. In this group just mentioned the majority of the patients were indigent. The majority of the patients in our group were private patients. In the group reporting distal antrectomy and bilateral vagectomy[6] 94 per cent of the patients gained weight, six per cent remain unchanged and 0 per cent lost. There was a 1.7 per cent occurrence of dumping and the gastric acid secretions returned to a normal range in all patients, and they had no trouble with any type of meal desired. In our series 66 2/3 per cent reported weight unchanged or gained and 33 1/3 per cent lost weight. Seventy-eight per cent were able to eat anything desired and 22 per cent were unable to eat anything desired. When our patients were allowed to classify themselves, as one group[4] did, 97 per cent were pleased with the results of their surgery and three per cent were not pleased. In the group[4] just mentioned, 100 per cent underwent partial gastrectomy with Billroth I anastomosis, and 14 per cent lost weight or failed to regain following surgery. Ninety per cent of the patients reported they were enjoying good results from their surgery, five per cent fair results and five per cent poor results. In 1942 Drs. Welch and Allen at the Massachusetts General Hospital reported[3] a seven year follow-up of patients undergoing gastrectomy for duodenal ulcer with Billroth I and Billroth II anastomosis.[3] They noted 49 per cent excellent results, eight per cent good results, 16 per cent poor and 13 per cent operative deaths. In their series it took six to 12 months to regain their

preoperative weight. The Billroth II anastomosis obtained the best results. They had a 20 per cent operative rate for duodenal ulcer disease. As was noted in our series, the number of dumpers was reduced from four per cent to one per cent when the patients were followed for at least three years.

In evaluating our patients with gastric ulcer, 73 per cent were treated surgically and 27 per cent were treated medically. There are two schools of thought in treatment of gastric ulcers.[10] One group would operate on all gastric ulcers and another group would individualize each case; that is, the majority should be studied and if the ulcer does not show signs of healing in seven to ten days surgery should be done. If signs of healing are evident but not nearly or completely healed in three to four weeks, then surgery should be done. The majority of prepyloric ulcers should be operated as 28 per cent are malignant and 72 per cent are benign. The indications for surgery in gastric ulcer disease are: obstruction, perforation, hemorrhage, carcinoma, inability to exclude carcinoma, failure to heal and recurrence of gastric ulcer. At least one-half of the stomach should be removed and a Billroth I or Billroth II reconstruction should be done and this group[10] reporting at Massachusetts General Hospital favored a Billroth I anastomosis. Fifty-seven and one-eighth per cent were treated surgically and 42.2 per cent medically. The average for the nation is 65 per cent with a mortality of two per cent. Dr. Samuel F. Marshall, etal[11] reported in 1961 that all patients with gastric ulcers should be given a medical therapeutic trial if no evidence of healing is noted, and a resection should be done in three to four weeks. At least a 50 per cent gastrectomy with a Billroth II anticolic Hofmeister anastomosis or Billroth I, depending on the location of the ulcer, should be done. Forty per cent of their patients were operated upon. Another group[9] reporting in 1964 preferred a Billroth I anastomosis following resection of gastric ulcer, if the ulcer is low lying, but an excision of the ulcer, if it is high, rather than a total gastric resection. One author[2] stated that gastrectomy will relieve 100 per cent of all the symptoms in gastric ulcer and the location is no criterion for medical management as all patients with gastric ulcers should be submitted to resection.

In our group the average was 52 years with 72 per cent males and 28 per cent females. The presenting complaints in our group were pain, weight loss, hemorrhage, or inability to heal on X-ray. A 2/3 gastrectomy with Billroth II anticolic Hofmeister anastomosis was most commonly used; secondly, a Billroth I and a Billroth II Polya anticolic reconstruction was done. Vagotomy with Billroth I or Billroth II was used in three patients with good results. Eighty-three per cent of our patients had a good result and 17 per cent had an unsatisfactory result with an operative mortality of four per cent. Twenty-seven or 12 per cent of our cases were gastric cancers and 100 per cent were surgically treated. The average age was 57 years with 70 per cent males and 30 per cent females. Nineteen per cent are living with a good result and 81 per cent are dead from one to ten years postoperatively. Of the patients who are living, one is eight years, two are four years, one is three years, and one is living two years postoperatively. One author[9] notes that in 14 per cent of his total cases with gastric neoplasm a radical subtotal Billroth II esophagogastric resection was done if the lesion was high. In 1957 Dr. Marshall[12] editorialized that a total gastrectomy should only be utilized in those patients whose disease process could not be removed completely otherwise, and should only be used when a cure is to be expected. It should never be done for palliative reasons. He also noted that this was fraught with an 8.2 per cent operative mortality against a 5.7 per cent operative mortality for subtotal gastrectomy. Fourteen point one per cent of the patients lived five years or longer. Radical partial resection of the stomach with removal of the spleen, lymphnodes and omentum is still the most satisfactory method of treatment and total gastrectomy was employed in one-third of the cases. Early recognition re-

mains paramount in the overall prognosis. A recent monograph[13] uses the guiding principle that surgery to be adequate, resection with safe margin, regardless of extent, should be done. They had good results with minimal resection and good results with maximum resection if the case was carefully chosen. If metastasis was present the results were bad; if they were not present, the results were much better. He noted that adenocarcinoma had the best prognosis and scirrhus carcinoma the worst prognosis.

It is obvious from the review of the analysis presented by Dr. Gaba, of 5125 duodenal ulcers only 149 or a little less than three per cent had some type of surgical procedure. Now, if you would take the number of ulcer cases treated in the out-patient clinic and add this to the 149 that had surgery, I think you would find it to be less than one per cent. This shows, without a shadow of a doubt, that patients have gone elsewhere and had surgery, or we have allowed too many to suffer too long without surgery.

A large number receive relief by surgery as 50 per cent obtained good results when a gastrojejunostomy was done 30 or more years ago. When other gastric procedures are done 90 per cent to 95 per cent receive good results.

As noted in this series, the average age was 49 and the average length of symptoms was 15 years. I personally feel those who have hemorrhaged more than twice, perforated, developed recurrent ulcer symptoms or have become intractable with only intermittent relief should not continue over a six to 12 month period without surgery. Those who have repeated attacks from scar tissue and complete or incomplete obstruction should be operated upon early.

I am sure patients have come to you begging to be operated upon to obtain relief, as they have seen numerous doctors with many treatments over a long period of time, refusing to return to their medical doctor. It is also true that, as surgeons, we have a good idea before we operate of those who are going to obtain the best results or complete cure from surgery. This is the patient who is suffering from intractable pain, obstruction, repeated hemorrhages and has not improved, although he is following his doctor's orders of diet, medication and refraining from smoking, coffee and alcoholic beverages. Therefore, he is able to relax mentally and physically.

The type patient who will not get good results is usually that patient who has gone for a long time taking advice from his neighbors. Usually he has seen many physicians, but does not adhere to treatment, continues to smoke, drink alcoholic beverages, had probably become partially addicted to narcotics to obtain relief and had probably received psychiatric treatment or needs it. Because of long duration of intractable pain and ulcer obstruction it is necessary to do gastric surgery, knowing they will not follow your treatment or advice. I know all of you have two or three patients like this which makes it seem like 200 or 300.

It is noted in the analysis of the different type of operations, whether it be vagotomy with pyloroplasty, partial gastric resection Billroth I or Billroth II with different modifications; the complications, dumping syndrome and recurrent ulcer are about the same, varying very little. In reviewing the literature, this is pretty well the findings of a large series of cases.[14]

Orr,[14] in a large series of 1603 cases, did three types of operations, alternating all consecutive cases. The results were about the same in all three.

Joseph E. Hamilton[15] and his group at Louisville, Kentucky, alternated 211 cases with vagotomy and drainage procedure, and gastrectomy. Of the 106 that had vagotomy and drainage, 89 per cent had good results. Of the 105 with gastrectomy, 88 per cent had good results. Complications were about the same as 12 in the first group had recurrent ulcers and eight recurrent in the second group.

J. C. Galigher[16] used controlled cases, doing three types of operations, alternating consecutive cases: vagotomy and pyloroplasty, vagotomy and antrectomy and subtotal gastrectomy. This includes 360 patients from 1959 to 1962. Overall, the patient's functional condition, capacity for work and enjoyment of life showed no significant difference in the outcome after all three operations. It is still about 50-50 vagotomy and pyloroplasty or antrectomy, versus subtotal gastrectomy with modifications of Billroth I and Billroth II.

Dr. Alton Ochsner stated in his personal experience with a 70 per cent-80 per cent subtotal gastrectomy, removing a large portion of the lesser curvature with a posterior gastrojejunostomy and leaving a three to four centimeter opening as close to the ligaments of Treitz as possible, that very little or no prolonged dumping resulted with few, if any, marginal or recurrent ulcers. These are the patients he has personally operated upon.

I think the patient obtains the best results by the surgeon doing the operation that he does best and obtains the best results. I personally favor subtotal gastrectomy Billroth II Hofmeister anastomosis close to the ligaments of Treitz, as Dr. Ochsner describes. This should not be used for all patients as selective operations will be done, depending upon the locations and the amount of pathology found at operation, the build and anatomy of the individual, other associated diseases and the condition of the patient at the time of operation. However, in benign gastric ulcers, my preference is an adequate gastric resection with Billroth I anastomosis. When there is cancer and no evidence of metastasis, a subtotal gastrectomy with adequate margins away from the cancer should be done. Always leave a portion of the stomach to keep the patient from being a gastric cripple.

Summary

Duodenal Ulcer—149 (67 per cent): Three per cent were treated surgically and 97 per cent were treated medically. Average age, 49 years; 81 per cent males and 19 per cent females. Presenting complaint: 1. intractable pain. 2. bleeding. 3. obstruction. 4. recurrent ulcers. Symptoms were present for an average of fifteen years. Operation: 2/3 gastrectomy with Billroth II anticolic Hofmeister anastomosis, Billroth II Polya anticolic anastomosis, Billroth I anastomosis; vagotomy with either Billroth I or Billroth II reconstruction. Ninety per cent good results, 10 per cent unsatisfactory results. One per cent dumper, four per cent overall dumpers, four per cent marginal ulcers and one per cent operative mortality.

Gastric Ulcer—46 (21 per cent): Seventy-three per cent were treated surgically and 27 per cent were treated medically. Average age, 52 years; 72 per cent males and 28 per cent females. Presenting complaint: pain with no or poor evidence of healing on therapy by x-ray; weight loss, hemorrhage, obstruction and/or combination of any of these. Operation: 2/3 gastrectomy with Billroth II anticolic Hofmeister anastomosis, Billroth I, Billroth II with Polya anticolic anastomosis; and vagotomy with Billroth I or Billroth II anastomosis. Eighty-three per cent good results and 17 per cent unsatisfactory results and an operative mortality of four per cent.

Gastric Cancers—27 (12 per cent): One hundred per cent were treated surgically. The average age was 57 years; 70 per cent males and 30 per cent females. Seven per cent underwent a 3/4 gastric resection with Billroth I anastomosis; 30 per cent had a 3/4 gastric resection and a Billroth II Hofmeister anticolic anastomosis; 30 per cent underwent a 2/3 gastrectomy with Billroth I anastomosis; 18 per cent a 2/3 gastrectomy with a Billroth II Hofmeister anticolic anastomosis; four per cent a 4/5 gastrectomy with Billroth I anastomosis and 11 per cent a total gastrectomy with an esophagojejunal anastomosis. Nineteen per cent are living and 81 per cent are dead. One is living eight years postoperatively, two are living four years postoperatively, 1 is living three years postoperatively and 1 is living two years postoperatively.

Miscellaneous: One patient with a duodenal carcinoma who underwent 3/4 gastrec-

tomy with Billroth II Polya anastomosis is mentioned. Five patients found to have duodenal and gastric ulcers are mentioned and 1 with a gastrojejunal colic fistula is mentioned.

An analysis of a twelve year experience of gastric resections at Carraway Methodist Hospital, a 316 bed community hospital in Birmingham, Alabama, is presented with statistical data and discussions.

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Surfers' Knots, Newest Athletic Injury

The newest status symbol of water sports are "surfers' knots," the knobby lumps which form on the legs and feet of surfboard riders, according to a recent article in the Journal of the American Medical Association.

The knots are apparently harmless, and although they cause occasional discomfort, they are regarded as a status symbol among some teenagers, reports Sheldon Swift, M. B., Ch. B., of the Department of Dermatology, Southern California Permanente Medical Group, Kaiser-Permanente Medical Center, Panorama City, Calif.

The knots are formed by friction between surfboard and skin, and are of two types. One type, which forms just below the knee, is a hard lump which is essentially a giant callus.

A more bothersome type appears on the upper surface of the foot. This is a softer cystic swelling which varies in size, and often grows rapidly after a day in the surf. It may rupture and discharge a white fluid.

"While some of us in Southern California and other coastal areas are familiar with these lumps, they sometimes cause alarm, and as the sport becomes more popular, physicians farther from the ocean will see these odd nodules," Dr. Swift said.

Evaluation Of Current Treatment Of Myocardial Infarction

by Malcolm I. Lindsay, Jr., Capt. MC.

from the Department of Medicine, Fort McClellan, Alabama

Presented at the Anniston Medical and Surgical Seminars sponsored by the Calhoun County Medical Society, December 9, 1964.

The mortality of acute myocardial infarction remains between 20 and 40 per cent. In this country alone, almost 200,000 lives are lost each year from this cause. Many of these deaths can be prevented, and for this reason the treatment commonly provided today is unsatisfactory. During the 15 years preceding 1960, discussion of this subject centered primarily on the use of anticoagulants. The controversy regarding their effectiveness distracted the clinician from a search for more fruitful methods by which to reduce the mortality of this disease. Although this controversy has not been settled to everyone's satisfaction, the past four years have seen a surge of interest in new therapies, and these will comprise a major portion of this presentation.

Certain principles of therapy for myocardial infarction are widely accepted, and do not warrant individual discussion. These include: administration of oxygen and adequate analgesia while pain persists, prompt treatment of associated shock or congestive heart failure, physical rest for the heart, and meticulous attention to the details of general nursing care. That these measures constitute the foundation of therapy is reflected in the mortality of only 12 per cent (after the first 24 hours) reported by Tillman in a series of cases in which these measures were emphasized, and anticoagulants were not used.[1]

Anticoagulant therapy after acute myocardial infarction is used to prevent intravascular or intracardiac thrombosis and embolism, both of which may be enhanced by ischemic injury of the endocardium, by reduced cardiac output, and by prolonged physical inactivity. A decreased incidence of clinically recognized thromboembolic events and a lower incidence of mural thrombosis at autopsy have been reported among patients treated with anticoagulants.[2]

Criticism of routine anticoagulant therapy has been based on the difficulties inherent in this therapy, the significant incidence of hemorrhage, and the relatively low incidence of thromboembolic complications when anticoagulant drugs are not used. In addition, there is still some doubt that the routine use of these drugs significantly reduces mortality from acute myocardial infarction. Table 1 shows data from two widely discussed studies, and from a smaller series in which I participated.[3]

The figures of Wright are those of the 1954 Report of the Committee on Anticoagulants of the American Heart Association, and summarize 1031 cases.[2] They have been interpreted as substantiating the effectiveness of anticoagulation. In Hilden's series, the reduction in mortality from 25 per cent to 23 per cent was not statistically significant, and he concluded that anticoagulant therapy is not indicated in acute myocardial infarction.[4] In all three of these studies, as in the bulk of published work on this subject, there is

TABLE 1

DATA ON ANTICOAGULATION IN MYOCARDIAL INFARCTION

	Deaths	Thromboembolism	Hemorrhage
Wright. 1031 cases.			
Control	21.7%	26 %	5.9 %
Treated	16	10.9	15.3
Hilden et al. 800 cases.			
Control	25	25	2
Treated	23	15	19
Lindsay and Spiekerman. 355 cases.			
Control	19.8	9.4	
Treated	17.6	5.8	3.8

an unmistakable reduction in thromboembolism and a small reduction in mortality from myocardial infarction among patients treated with anticoagulants.

While I believe the use of these drugs is justified, I wish to emphasize the remaining mortality of 20 per cent or greater, and turn now to a consideration of the new therapies which have been introduced in the past four years, and which offer real promise for reducing the mortality of this disease.

Autopsy series of patients dying from myocardial infarction disclose at least 25 per cent in which neither recent nor old coronary occlusions or infarcted myocardium are found.[5,6] Recent experience throughout the country has confirmed the suspicion that many of these patients die of ventricular fibrillation or other ectopic rhythm associated with inadequate support of circulation.

In 1956 Zoll introduced the use of externally applied electric countershock to terminate ventricular fibrillation.[7] He used an alternating current defibrillator, and reported four cases in which defibrillation was successful, with one survivor. Electric current applied in this manner instantly depolarized the myocardium, extinguishing the ectopic sites and permitting resumption of normal sinus activity. Because restoration of normal cardiac function required almost immediate availability of the defibrillator, few successes were reported.

The introduction by Lown of the direct current Cardioverter, utilizing the principle of synchronized capacitor discharge, represents a distinct refinement in the treatment of ventricular fibrillation. The more pronounced success of this instrument, however, has been in the treatment of ventricular tachycardia and other ectopic rhythms, many of which complicate acute myocardial infarction and add to its mortality if not promptly and expertly reversed.[8]

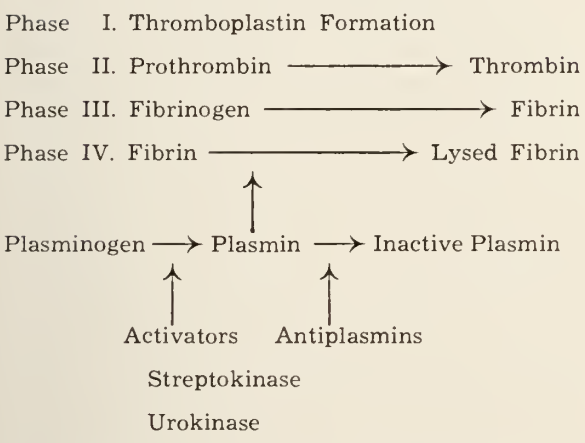
In 1960 Kouwenhoven introduced the concept of closed-chest cardiac massage, by which effective cardiac output and systemic blood pressure may be maintained by application of intermittent pressure over the lower sternum.[9] He has reported successful closed-chest resuscitation in seven of 28 cases of cardiac arrest in the presence of myocardial infarction; with his report cardiac resuscitation became a practical procedure for use on the medical ward as well as in the operating room.

Equipped with these tools, many physicians realized the potential salvage of lives which might occur through prompt diagnosis of cardiac arrest and immediate institution of closed-chest massage with assisted respiration, followed by defibrillation or appropriate drug therapy or cardiac pacing. Hospital nursing personnel were instructed in Kouwenhoven's technique. In some hospitals, teams of physicians were established to respond to an emergency call in the event of cardiac arrest, for the purpose of carrying out resuscitation when possible. In January 1964 such a team at St. Vincent's Hospital in New York City reported successful resuscitation and long term survival in 15 per cent of a series of 60 cases.[10] They cited as the major deterrent to a higher success rate the failure of early recognition of cardiac arrest when it occurred unexpectedly on the hospital wards. A delay of more than five minutes almost precludes success.

The natural evolution of these techniques and experiences leads to the development of a Central Coronary Care Unit, an area of the hospital set aside for the intensive care of patients with myocardial infarction, similar in philosophy to the postoperative intensive care unit. Such a unit would include a central multichannel physiologic monitoring system, by which a continuous oscilloscopic electrocardiogram and recording of arterial pressure or pulse volume would be transmitted from each patient to the central nursing station. An electronic sensing device and alarm actuated by ventricular fibrillation, ventricular asystole, or by predetermined changes in heart rate or blood pressure may be a part of this equipment.[11] The Coronary Care Unit would also provide nursing personnel trained in all aspects of care of the coro-

TABLE 2

COAGULATION AND FIBRINOLYSIS



nary patient, and especially in the use of the monitoring devices and the initiation of cardiac resuscitation. Other integral parts of the unit are a mobile emergency cart equipped with a defibrillator, an external cardiac pacemaker, a source of suction, laryngoscope and endotracheal tube, and the basic cardiac drugs, and most important, the constant availability of one or more physicians prepared to manage all aspects of cardiac resuscitation.

Experience with a Coronary Care Unit of this type at the Bethany Hospital in Kansas City was recently published.[12] During its first year of operation, a drop in mortality from myocardial infarction was observed from 39 per cent to 19 per cent. Five of seven patients who developed unexpected cardiac arrest were successfully resuscitated, and were well at the time of publication.

I believe the patient with myocardial infarction is as deserving of this type of intensive care as is the patient who has undergone cardiac surgery. In the establishment of this kind of facility I foresee a realistic hope for substantial reduction of the mortality from this disease.

A number of additional therapies for myocardial infarction remain in the stage of experimentation, but are either sufficiently promising or so widely discussed that they merit our consideration. First among these is thrombolytic therapy. Table 2 presents a simplified scheme of the physiologic systems of coagulation and fibrinolysis. The primary mechanism of clot lysis involves adsorption of plasminogen activators on the thrombus, activation of intrinsic clot plasminogen to plasmin, and lysis of the thrombus from within.

The clinician's problems with regard to thrombolytic therapy in myocardial infarction are to administer the necessary amount of a satisfactory clot-lysing agent to the patient whose coronary artery has been occluded by a thrombus within the previous several hours, to accomplish this administration without substantial discomfort or risk, to monitor the thrombolytic effect during administration, and to accurately assess the results of this treatment. Since only 40 per cent to 80 per cent of myocardial infarctions are the result of coronary thrombosis, the remainder being due to atheromatous plaques, hemorrhage into plaques, or to emboli, there is no certainty in the individual case that the thrombolytic agent will serve a therapeutic function. When thrombosis is present, best results are obtained when the thrombolytic agent is administered within 10 hours of clot formation. Delays in diagnosis and hospitalization often prevent the initiation of this therapy within such time.

Because the drug must be uninhibited or free in the plasma to be active in clot lysis, and because plasma contains inhibitors to each stage of the thrombolytic system, dose measurement is complicated by the necessity of exactly neutralizing the inhibitors with a priming dose before additional drug will cause active thrombolysis. This necessitates preliminary measurement of the circulating inhibitors.[13]

Monitoring the effect of thrombolysin or other lytic agent during the infusion is necessary to prevent hemorrhage from a hyperplasminemic state. Several methods have been employed; all are complex. Measurements of prothrombin, plasma fibrinogen, plasminogen, and activator are among the more important.

Evaluating results of this therapy is also difficult. The absence of a thrombus at autopsy is without meaning if there is no proof that a thrombus existed originally as the cause of infarction. Clinical studies have disclosed more rapid evolution of the electrocardiographic changes which accompany myocardial infarction when a thrombolytic drug is employed. The significance of this is uncertain. Initial studies, using a standard dose of lytic agent, which cannot be satisfactory for the reasons mentioned above, disclose no reduction in mortality from acute myocardial infarction.[14] If all this sounds complicated, it is. Experimentally, however, ischemic myocardium is salvaged by the use of these drugs, by lysis of microthrombi in the collateral circulation even prior to lysis of the major obstructing clot. The possible rewards are great, but at present the use of thrombolytic agents can be encouraged only under conditions of strictly controlled clinical investigation.

A second area of experimental interest and beginning clinical application is the use of hyperbaric oxygen therapy. At increased pressures, usually two or three atmospheres absolute pressure, the oxygen carrying capacity of blood is greatly increased. Sufficient oxygen may be carried in plasma by simple solution under these conditions to sustain life in the absence of red blood cells and of hemoglobin. The tissues become saturated with unusually high concentrations of oxygen. Two effects of this therapy in the subject with myocardial infarction are increased diffusion of oxygen into the peripheral areas of ischemic myocardium, reducing the ultimate size of the infarction, and a protective effect against development of ventricular fibrillation. In a series of 50 dogs subjected to ligation of the circumflex coronary artery, Smith reported a mortality of 10 per cent among those treated postoperatively with hyperbaric oxygen at two atmospheres as opposed to mortality of over 50 per cent among the controls.[15] Trapp studied the size of infarct resulting from ligation of the left anterior descending coronary artery in dogs, and found a reduction of more than 50 per cent among animals treated postoperatively with hyperbaric oxygen at three atmospheres pressure.[16] Initial case reports, but no controlled series of the use of hyperbaric oxygen in human myocardial infarction have been published. The major deterrents to widespread use of this therapy are the great cost of the hyperbaric chamber, and the training necessary for its safe application.

The last area for discussion is the role of surgery in acute myocardial infarction. A year ago Nardi and Shaw reported four cases of emergency coronary endarterectomy from the Massachusetts General Hospital.[17] Each of these patients was taken to surgery after cardiac arrest and failure of conventional cardiac resuscitation. One patient lived 52 hours following surgery; the others failed to revive. Although heroic in execution, it seems unlikely that many lives will be salvaged in this way. Perhaps coronary endarterectomy will be more profitable when applied to selected cases prior to their demise.

A less dramatic but possibly more helpful application of surgical techniques is the use of left heart bypass, as suggested by Dennis, in cases of shock or refractory congestive heart failure complicating myocardial infarction.[18] A catheter may be passed down the right internal jugular vein into the right atrium, and then through the septum of the fossa ovalis into the left atrium. Blood removed from the left atrium through this catheter may be returned to the aorta via femoral artery catheter. The purposes of this procedure are to supplement cardiac output, increase coronary perfusion, and diminish the work load and oxygen requirement of the myocardium. In experimental animals, myocardial oxygen consumption can be reduced about 40 per cent with this technique.

In conclusion: The rate of mortality from acute myocardial infarction has not declined in accord with the general advancement of medical technology. New therapies are being developed. Most promising among these is the development of Central Coronary Care

Units within hospitals, utilizing electronic aids for constant monitoring of cardiac function, and for resuscitation when necessary. The use of thrombolytic agents, hyperbaric oxygen therapy, and surgical techniques remain in the stage of clinical investigation.

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Psychosomatic Academy Announces Annual Gold Medal Award

The Academy of Psychosomatic Medicine announces the Annual Gold Medal Award contest for the best paper (not over 4,000 words) on a clinical or research subject in the field of psychosomatic medicine.

The winner will receive the Gold Medal and deliver his paper at the 12th Annual Convention of the Academy of Psychosomatic Medicine in Chicago, Illinois, October, 1965, and the paper will be published in Psychosomatics the official journal of the Academy.

The winner's travel expenses will be paid to and from the meeting. The committee reserves the right to submit all articles including the winning entry, to PSYCHOSOMATICS, the official Academy journal. Manuscripts not accepted for publication by PSYCHOSOMATICS will be returned to their authors.

The deadline date for submission of manuscripts is July 1, 1965.

For full particulars write to Benjamin Schneider, M. D., Chairman, 123 E. Market Street, Danville, Pa.

Pediatricians Enlisted In War On Cigarette Smoking Habit

The American Academy of Pediatrics has issued a statement opposing the smoking of tobacco in cigarettes and urging its 8,500 members to join "in every effort to discourage acquisition of the habit of cigarette smoking during childhood and adolescence."

Experiments Show Bees 'Taste' Honey

Is taste electrical or chemical?

What are the effects of a depressant in taste areas?

Kamal Yackzan, who earned his doctorate at the University of Alabama Medical Center in physiology and bio-chemistry, conducted a research project on the physiology of taste, using the honey bee as an experimental subject.

He selected honey bees for study because there are narrow variables in the taste area of a honey bee.

Yackzan, a native of Lebanon who became an American citizen in 1960, conducted his doctorate research project on the biological effect of gymnema sylvestre—an Indian plant which depresses man's abilities to taste sweet and bitter substances—on the honey bee. He also tried it on hamsters and rats.

Using electronic equipment, Yackzan extended his study to show depression in taste involves other taste substances—acid and salt —when the study was done by electrophysiological means on the hamsters.

Finding the right receptors sensitive to sugar on the tongue of a bee was difficult because there are so many hairs on a bee's tongue. Little scientific research had been done on the honey bee, but Yackzan, through correspondence and Medical Center Library facilities read the meager literature that exists on the subject. He reviewed the publications of a German named von Frisch, who conducted experiments to prove by behavioral studies that honey bees "taste" honey.

Using electronic equipment he found there is a chemical reaction on the receptor on the tongue of the bee. In other words, a honey bee is able to sense or taste sugar, which means taste is a chemical phenomenon which is translated into electrical signals.

Research on a separate topic involving the plant gymnema sylvestre suggests a possible future use of this plant in treatment of gastric hyperacidity and its sequels.

Yackzan, who recently completed his research project at the Medical Center's Department of Physiology, has joined Auburn University as associate professor in the Department of Physiology and Pharmacology. He is married to the former Morwenna Robinson, a native of Alabama. Dr. and Mrs. Yackzan have six children.

Yackzan's studies started in his native Lebanon. He won a scholarship to high school in Cairo, Egypt, and attended his first year of college at the University of Cairo. He came to Birmingham to study at Birmingham-Southern College, where he earned his B.S. in biology. He next earned his M.S. in biochemistry from Vanderbilt University. He also earned graduate credits at the University of Tennessee at Memphis, Florida State University and he attended the American University at Beirut, Lebanon. He taught at Memphis State, University of Alabama Extension Center in Gadsden, Florida State and Alabama College. He was a visiting lecturer at Randolph Macon College.

Knowhow Is Knowhow Is Knowhow

The pharmaceutical industry . . . has developed a great deal of knowhow in the preparation of drugs so as to insure the stability, purity and reliability of their products. The excellent work done by the Food and Drug Administration to insure purity in food and drugs has borne fruit and no sensible manufacturer would release imperfect or impure agents for use. Furthermore, manufacturing controls have become much more effective. The pharmaceutical industry can take great pride in its achievements in insuring that its products have the type of purity and stability needed for use in man.—Dale G. Friend, M. D., in *Journal of the American Pharmaceutical Association*, NS4: 11, (Nov.) 1964.

Recommended Dosage of Lomotil Liquid to Control Diarrhea

File: Diarrhea

LOMOTIL®

Age	INITIAL LOMOTIL LIQUID DOSAGE*
3-6 mo.	½ tsp. t.i.d. (3 mg.)
6-12 mo.	½ tsp. q.i.d. (4 mg.)
1-2 yr.	½ tsp. 5 times daily (5 mg.)
2-5 yr.	1 tsp. t.i.d. (6 mg.)
5-8 yr.	1 tsp. q.i.d. (8 mg.)
8-12 yr.	1 tsp. 5 times daily (10 mg.)
Adult	2 tsp. 5 times daily (20 mg.) (or 2 tablets q.i.d.)

*Based on 4 cc. per average teaspoonful.
Note: After diarrhea is controlled the initial dosage can usually be reduced to meet the requirements of the individual patient.

LOMOTIL® TABLETS/LIQUID

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride .....2.5 mg.
(Warning: May be habit forming)
atropine sulfate .....0.025 mg.

Precautions
Lomotil is an exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates.

Cautions and Side Effects
Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia.

Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

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Editorial COMMENT

GUEST EDITORIAL

The Latest National Nostrum

By John P. Lynch, M. D.

The Administration's proposed war on the three major diseases, which constitute the cause of 71 per cent of all deaths, is just as politically cynical as the war on poverty, and for essentially the same reason. It proposes to squander tax monies to solve suddenly, on a crash basis, problems which, from the beginning of man, have occupied the minds of our best scientists and physicians. Many of these problems are so basic that they will never be solved until we have learned the origin and physiology of living tissue, the meaning of life, and the way to insure immortality. I am a little surprised that the goal was not set against mortality rather than only 71 per cent thereof. Of course, 70 per cent has long been considered a passing mark and politicians have to be practical even in health matters.

On December 27th, on a panel type television program, three nationally known physicians appeared to promote this surprising hoax on the American people. They intimated that if, what they, and their grant-supported institutions knew, could be disseminated to the level of the practicing physician there would be a sharp reduction in mortality. For instance, cancer mortality could be reduced from saving one out of three, to one out of two, and by recognizing early signs of stroke vast numbers of people could be spared this disabling disease. How preposterous, how cruel such statements are when they come from supposedly recognized leaders in their field. Their knowledge of New York and Houston is gained under ideal experimental circumstances, in highly selective patients, carefully screened to fit their particular interests. They seem to have lost their perspective for what really confronts the practitioner in dealing with people.

Their grandiose scheme to bring knowledge down from on high through the establishment of four hundred health centers throughout the country is patently political, an ominous step toward State medicine. What do they think the fine medical schools of this country are doing, and have been doing for the past hundred years? Are they not bringing the latest techniques to students and practitioners by continued education programs? Are not the great specialty organizations such as the American College of Physicians, and the American College of Surgeons busily engaged in continued education programs, as are many local and state and national medical associations? Have not the great free enterprise pharmaceutical houses of America already expended millions of dollars in profitable research in advancing the role of antibiotics and steroids and other miraculous drugs, and won't they continue unless hampered by Government's heavy hand? These nationally known grant-sup-

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Editor's Note: *Dr. Lynch is chairman of the Committee on Aging and Chronically Ill of The Medical Society of Virginia.*

Guest Editorial . . . , *The Virginia Medical Monthly, March* 1965 *Vol.* 92, *No.* 3.

One antibiotic superior to
Tetracycline
Chloramphenicol
Streptomycin
Kanamycin
Polymyxin B
Penicillin G
against Proteus mirabilis and E. coli



Proteus mirabilis is not only the most common cause of *Proteus* infections of the urinary tract, but such infections are often resistant to other antibiotics.[1-4] According to Anderson *et al.*,[5] "When assessed in terms of serum levels attainable with usual dosage regimens, ampicillin was the most effective drug tested against *E. coli* and *P. mirabilis*." These authors found *Klebsiella-Aerobacter* and *Pseudomonas* organisms relatively insusceptible to ampicillin. With its broad-spectrum coverage of many gram-positive and gram-negative bacteria, absence of toxicity, and slow emergence of resistant strains, PENBRITIN (ampicillin) is a most beneficial and safe drug in treating urinary tract infections—*killing* the pathogens, not just suppressing them.

Dosage: Adults—500 mg. every six hours (higher doses may be required for severe infections). Children—(under 13 years, whose weight will not result in a dosage higher than that recommended for adults) 100 mg./Kg./day in divided doses every six or eight hours for moderately severe infections; 200 mg./Kg./day in divided doses every six hours for severe infections.

Contraindications: (1) Hypersensitivity to penicillin. (2) Infections by penicillinase-producing staphylococci and other penicillinase-producing organisms. *Aerobacter aerogenes*, *Pseudomonas pyocyanea*, and *Proteus morganii* are resistant to PENBRITIN (ampicillin).

Side Effects: Mild effects, such as skin rashes, diarrhea, nausea and vomiting, have occasionally appeared.

Precautions: As with other antibiotics, precautions should be taken against gastrointestinal superinfection. To date, safety for use in pregnancy has not been established.

Supplied: No. 606—Each capsule contains 250 mg. of ampicillin. Bottles of 16 and 100.

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ported physicians think in terms of what will best further interest of the welfare state. They seem to care little about the doctor-patient relationship. To them statistics seem more important than people and subsidies than free enterprise. The whole situation reminds one of the western medicine shows of the last century, only the stakes are higher, and our Leader is the medicine man.

Are we beginning to witness the take-over of American Medicine by an all wise, all powerful Government which uses every power of a totalitarian state by control of television and other news media and the creation of an elite coterie of health commissars which by virtue of their grants speak for this Government in a superior and paternalistic way? This group looks down on the opinion of the American Medical Association as though it was unworthy to represent the physicians of this country and not to be considered by any but the most benighted, backward supporters.

In the December 28, 1964 issue of Medical Economics it was stated the "Federal Government poured $309,212,409 into United States medical schools in 1963. This is 51 per cent of what the schools spent for all purposes that year." Of course, almost a third of a billion is chicken feed to the proposed three billion dollar program to promote the war on three major diseases. Medical education has been taken to the extent of 51 per cent and now the Federal Government bids strongly to take over medical practice.

It is to be hoped fervently that the American people will awaken to this peril before it is too late. The Great Society will never be worth sacrificing the principles upon which these United States were founded.

A Slander Against The Doctors of Alabama

The State of Alabama and its people have suffered grievously during the past few years as a result of the civil rights fight. We have been held up to public ridicule and contempt as a backward section of unwashed bigots, lynch mobs and kluxers.

Almost without exception, the physicians of this State have remained aloof from this sociological embroilment. True to the traditions of our profession we have continued patiently and faithfully to discharge our obligation to minister to the needs of all races and all creeds.

Our refusal to become involved does not indicate a lack of interest or concern for the future of our state but, rather, an iron-willed determination to set an example for all citizens of calm, intelligent approach to problems which beset us.

It is, therefore, disturbing to find the medical profession of Alabama indicted by innuendo on the front page of the *AMA News* (April 5, 1965) for reneging on our sacred obligation as physicians or, to say the least, for being absent in a time of crisis.

The *AMA News* quotes David French, M. D., a member of the Medical Committee for Human Rights as saying that sore and blistered feet, sunburn and windburn constituted the major medical problems encountered by the Selma-to-Montgomery demonstrators. To minister to these needs were "many Alabama Negro physicians as well as about 50 M. D.s from other states who are active in the MCHR."

The marchers, *AMA News* continues, were accompanied by ambulances and an aluminum mobile field hospital. Military helicopters had been offered to transport patients to nearby military hospitals but were not needed.

And where were the members of the Dallas County Medical Society during all this activity?

At a recent meeting of the State Board of Medical Examiners an official stated:

1. No requests for additional assistance from any of the county medical societies, or from any group of Alabama physicians, were received;

to help relieve pain
in common
anorectal disorders

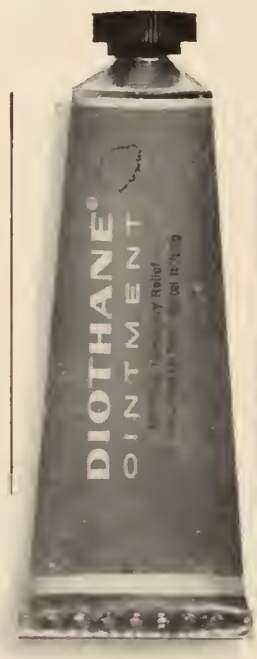
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Diothane—with its chemically distinct "non-caine" anesthetic agent diperodon—provides effective temporary topical anesthetic and emollient actions for soothing relief of anorectal pain. Anesthetic activity is effective and relatively prolonged; sensitization is infrequent. Reports to Merrell on 1,500 patients treated pre- and postoperatively with Diothane Ointment, indicate only 22 developed local skin reactions. Reactions to Diothane have been burning or stinging sensations and a few cases of allergic manifestations. An additional advantage: Diothane Ointment and Suppositories are mildly antiseptic. Prescribe or recommend either form...both are now available.

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diperodon 1.0%; oxyquinoline benzoate 0.1% in a special ointment base.

INDICATIONS:
Provides temporary palliation of pain that may result from hemorrhoidectomy and from common anorectal disorders such as hemorrhoids, anal fissures, pruritus ani.





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COMPOSITION:
Each suppository, weighing approximately 2.6 Gm., contains diperodon 1.0%; urea 10.0%; oxyquinoline benzoate 0.1% in a special hydrophilic suppository base. A unique shape keeps the suppository in intimate contact with mucous membranes.

INDICATIONS:
Provide for temporary palliation of pain caused by hemorrhoids and pruritus ani.

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2. Selma physicians made local arrangements to render needed medical care in their hospitals; and that,

3. Several physicians from other states, not licensed in Alabama, brought in a trailer and claimed to be preparing to administer emergency care to demonstrators at some future time.

The official quite properly noted that the establishment of an office and advance preparation for an emergency constitutes the practice of medicine and is quite different from first aid rendered by anyone, including a physician, who suddenly finds himself faced with a problem that was not anticipated.

It has been rumored that two of the three deaths which occurred during the Black Belt demonstrations might well have been averted. Perhaps the Federal investigators, now so active in this State, will want to delve a little more deeply into these cases.

Alabama's Role In The Eldercare Fight

The Johnson Administration's relentless drive to ram socialized medicine down the throats of the American people under the guise of providing medical care and hospitalization for the needy aged is moving into its final phases in the U. S. Congress. Before another issue of the Journal is published the issue most likely will be resolved.

Physicians of Alabama performed admirably in this crucial fight which must certainly revolutionize the practice of medicine as we now know it. Through countless letters, telegrams and telephone calls the Congressional delegation from this state was made aware that government-controlled medicine violates our concept of freedom.

That this campaign was successful from the standpoint of Alabama physicians there can be no doubt. Every Congressman from Alabama stood firm against the Medicare bill from the casting of the first vote to the last. If every other state had achieved equal success this ogre would now be forever dead.

But such was not the case, and Medicare has passed the House with a respectable margin (although not by the overwhelming numbers predicted for it last November). It is now being considered by the Senate where it is likely to receive a more penetrating study than the House gave it.

Each succeeding public opinion poll after Johnson's landslide presidential victory last fall disclosed that Americans in increasing numbers were taking second looks at a compulsory health program which covered everyone over 65 years of age. From every section of the nation the trend was toward the more democratic voluntary plan sponsored by organized medicine.

This change in public opinion is directly attributable to the educational program conducted by the doctors of America.

Here in Alabama every conceivable method was used to state our position to the public. Pamphlets by the thousands were distributed to organizations and individual citizens. More than one county medical society spent its own funds for television and radio broadcasts and for newspaper advertising.

A series of 11 meetings designed to bring together the leadership of all 67 county societies was held throughout Alabama. The records show that these meetings were attended by not less than 10 per cent of the total membership of the Medical Association of the State of Alabama. Some of these meetings lasted late into the night as enthusiasm for the fight waxed hotter.

Not to be forgotten is the cooperation extended by the ladies of the county Auxiliaries. They assumed the task of distributing materials and they also made their voices heard in countless other ways.

Busy doctors took time off to appear before civic clubs, on radio and television whenever

they were requested to do so. There is ample evidence that their efforts were not in vain.

Profiting from past mistakes, this latest fight against Medicare was to be organized and conducted from the grass roots. AMA provided one-half the campaign funds in Alabama, the state association and county societies provided the balance.

Did we win, or did we lose? Whatever may be the outcome of the Medicare bill, there can be no doubt that Alabama's physicians are in a more advantageous position, politically speaking, than ever before. For one thing, we have learned the value of united effort. In the months and years ahead, when selfish interests threaten our welfare, we will use this knowledge, and this experience, to counterattack until the victory is won.

• • •

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FAMOUS ALABAMA PHYSICIANS

DR. ROBERT ARCHIBALD LAMBERT (1883-1960), who spent 20 years on medical education and research in four universities—Columbia, Yale, Sao Paulo and Puerto Rico—closed his distinguished career with an equal period as Associate Director of Medical Sciences of the Rockefeller Foundation.

He was born on a farm about seven miles from Lamison in Wilcox County and lived there until he was seven years of age when his family moved to Catherine. He attended a one-room school and later prepared for college by attending the South Alabama Institute for three years.

Later, he attended Howard College in Birmingham where he earned B.A. and M.A. degrees, the latter in 1903. He taught in the Anniston school system for two years and then decided to enter the medical profession.

Lambert selected Tulane University School of Medicine for his medical education and graduated May 8, 1907. After two years of postgraduate study in pathology at Johns Hopkins University, he joined Columbia University as an assistant pathologist. In 1911 he was elevated to associate pathologist, a position he held until 1917.

During World War I, Dr. Lambert served as acting head of the Department of Pathology at Columbia.

While at Columbia, Dr. Lambert twice interrupted his career to embark as a medical officer, once with the Rice Scientific Expedition to the Amazon regions of Brazil, and later as director of laboratories for the Near East Relief Mission in Syria and Turkey.

In 1919, Dr. Lambert was invited to join the faculty of the Yale University School of Medicine. He remained at Yale four years before being appointed Professor of Pathology and Anatomy, Faculdade de Medicine de Sao Paulo, Brazil—a position sponsored by the Rockefeller Foundation.

Then, in 1926 under the sponsorship of Columbia University, Dr. Lambert served as Professor of Pathology and Director of



the School of Tropical Medicine at the University of Puerto Rico.

In 1929, Dr. Lambert joined the Rockefeller Foundation as Associate Director for the Medical Sciences, a position he held until his retirement in 1948.

His vast store of technical experience and knowledge was soon recruited again following his retirement. Dr. Lambert became consultant for the Pan-American Sanitary Bureau Regional Office of the World Health Organization in Washington, D. C.

Early in his medical experiences, he became interested in furthering the education of Negroes and in 1951 he accepted an appointment on the Interim Committee of Meharry Medical College in Nashville, Tenn. Eventually, he became acting president, and later chairman of the Board of Trustees.

Dr. Lambert then returned to his home in Greensboro and promptly was named to the Southern Regional Education Board.

Dr. Robert Lambert's distinguished career came to an end November 20, 1960, a few weeks after his 77th birthday, when a fatal heart attack claimed one of Alabama's most famous physicians.

One of a series of Famous Alabama Physicians based on research compiled by Dr. E. B. Carmichael for

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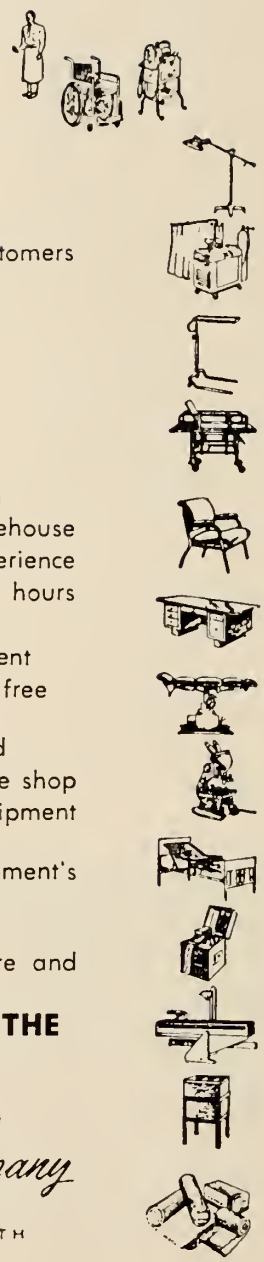
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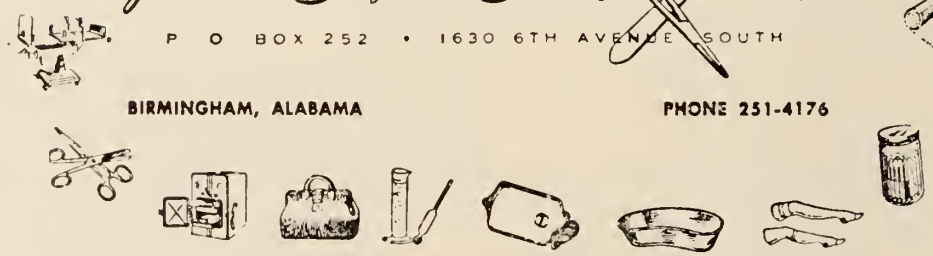
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Dr. Donald Takes Over At Annual Session; Dr. Finney Chosen President-Elect

One of the most successful annual sessions in the history of the Medical Association of the State of Alabama was climaxed last month in Birmingham by the selection of Dr. J. O. Finney as president-elect.

The association also elected Dr. Frank M. Phillippi of Brewton as vice president for the Southwest District succeeding Dr. E. L. Strandell who was ineligible for reelection having served two full terms.

Dr. Harmon Stokes of Dothan was elected to a full term as vice president for the Southeast District and Dr. H. E. Askin of Alexander City also was elected to a full term from the Northeast District.

Dr. Stokes was named vice president on the only ballot cast during the business meeting, winning over Dr. T. R. Lumpkin of Tuskegee. All other officers elected were done so by acclamation.

Two men, Dr. Hugh E. Gray of Anniston and Dr. John M. Chenault of Decatur, were named to a second term on the State Board of Censors while the Board of Trustees took on a new look with the election of Dr. Jean Clark of Vincent to succeed Dr. T. B. Norton of York. Dr. Vincent is the first woman to serve on the Board.



Dr. James G. Donald of Mobile, the new president, takes over the rostrum.

All vacancies in the College of Counsellors were filled by the present incumbents—Dr. Cecil E. Kimbrough and Dr. Arthur Wood from the First District, Dr. Samuel Windham



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Staff members from MASA and other volunteers are shown registering doctors at the main registration desk in the lobby of the Parliament House.

from the Second, Dr. James E. Cameron from the Fifth and Dr. Paul Burleson, Dr. Benjamin Carraway, Dr. William E. Coleman and Dr. Joseph A. Cunningham from the Ninth.

The Committee on Legislation held an emergency meeting on the opening day of the session to discuss several bills which had been under study for possible introduction in the regular session of the Alabama Legislature.

Only one measure was approved for Association sponsorship—a bill to establish certificates of qualification for foreign-born instructors at the Medical College of Alabama.

The Committee also approved a bill, to be sponsored by the American Legion, to protect the abused child provided it assigns responsibility for reporting cases of abuse to all persons having knowledge of the incident.

Tabled for further study were bills to legalize voluntary and eugenic sterilization and to relieve doctors, dentists and nurses from civil liability in the performance of "good Samaritan" acts.

The 1965 session's scientific program, which was well attended at all three sections, was highlighted by the Jerome Cochran Lecture, delivered this year by Dr. W. M. Christopherson, chairman of the Department of Pathology of the University of Louisville School of Medicine.

Dr. Christopherson's subject was "The Early Diagnosis of Cancer."

Other convention highlights included the presentation of the William Crawford Gorgas Award to Mr. and Mrs. J. S. Smolian of Birmingham, the presentation of the Douglas L. Cannon Medical Reporter Awards to Davenport Smith of Birmingham and Virginia Greer of Mobile, and the recognition of the Fifty Year Club whose new members were honored, along with association past presidents, at a special breakfast.

(Continued on Page 412)



It looks like fun time as the new president-elect, Dr. J. O. Finney of Gadsden, (left) and immediate past president Dr. E. B. Glenn (center) talk to Dr. John Chenault of Decatur. Dr. Chenault was re-elected to the Board of Censors and also was named to represent the Medical Association at a public U. S. Senate hearing in Washington concerning the medicare bill.



Dr. Vaun Adams of Mobile introduces a resolution.



Association Executive Secretary W. V. Wallace, left, and Dr. W. L. Smith of Montgomery, secretary-treasurer, confer during business session.



Past-President's Plaque is presented Dr. Glenn by Dr. Donald.



Dr. John Paul Jones of Camden, chairman of the Board of Censors, addresses the association as it sits as the State Board of Health.



Dr. Glenn, (extreme right), swears in three newly elected vice presidents—Dr. Harmon Stokes of Dothan, Dr. Frank Phillippi of Brewton and Dr. H. E. Askin of Alexander City (left to right).



Four members of the new Board of Trustees swap stories after their election. Left to right, they are Dr. H. G. Hodo of Fayette, Dr. R. M. Miller of Decatur, Dr. L. B. Cooper of Elba and Dr. Buford Word of Birmingham.



Dr. N. S. Flowers of Mobile invites the association to the Port City for its 1966 annual session.

DR. DONALD TAKES OVER . . .

(Continued from Page 409)

In addition to attending scientific papers and tending to association business, the meeting saw doctors meet as the State Board of Health and hear a report by Dr. Ira Myers, state health officer, who was given a standing ovation at the conclusion of his speech.

Non-association activities included a wide variety of exhibits just outside the meeting hall, the annual Scroll and Key Dinner Dance, and a barbecue hosted by the Norwood Clinic for association members and their guests.

The association received invitations from the cities of Birmingham and Montgomery to be the site of the 1968 and 1967 sessions respectively and the city of Mobile renewed its invitation to be hosts for next year's annual gathering.



Of 341 patients with confirmed OB-GYN infections... 320 or 93.8% were treated successfully with Signemycin®

Note:
In 50 cases of serious puerperal and postabortal infections treated with Signemycin, complete cure was observed in 49 patients.* Duration of therapy ranged from three to eight days. Appropriate surgical measures were applied as indicated.

*Heredia Diaz, J. et al.: Medicina (Mex.) 38:308, July 10, 1958.

Condition	No. of Patients	No. Responded to Signemycin
Abortion, infected	45	44
Adnexitis (parametritis)	66	61
Cervicitis	18	18
Endometritis	64	61
Mastitis and breast abscess	44	42
Puerperal sepsis	14	14
Salpingitis	39	34
Other ob-gyn infections	51	46
Totals	341	320 (93.8%)

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tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

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Dr. J. P. Collier of Tuscaloosa and Dr. John Paul Jones confer during business session.



Dr. W. A. Edwards of Wetumpka takes the floor.

ABOUT YOUR NEW PRESIDENT-ELECT

Dr. J. O. Finney of Gadsden, president-elect of the Medical Association of Alabama, is a native of Florence, Ala. Dr. Finney has been practicing in Gadsden for the past 29 years except for a five-year period during World War II when he was a U. S. Army medical officer. He specializes in internal medicine.

Dr. Finney received his A.B. and M.D. Degrees from Vanderbilt University and interned at the Vanderbilt University Hospital.

Professional honors accorded Dr. Finney have been numerous. He is a Fellow in the American College of Physicians, a Diplomate on the American Board of Internal Medicine, is Clinical Professor of Medicine at the Medical College of Alabama and is consultant in medicine at the Veterans Hospital in Birmingham. He also is Chief of Medical Service at the Holy Name of Jesus Hospital in Gadsden.

Dr. Finney also is past president of the Alabama Society of Internal Medicine and past president of the Alabama Heart Association.

Currently, he is president of the Vanderbilt University Medical Alumni Association and a trustee of Snead College in Boaz, Ala.

Dr. Finney is married to the former Margaret Pride of Florence.



Members of the Mobile delegation and other delegates examine reports and resolutions as the association met officially as the State Board of Health.



Of 1,028 patients with confirmed respiratory infections... 954 or 92.8% were treated successfully with Signemycin®

Note:
Hammerl* selected his patients for treatment with Signemycin on the basis of demonstrated bacteriological resistance to other antibiotics or failure of previous therapy. Of 100 patients with various respiratory tract infections, 95 responded to Signemycin. Pathogens isolated included staphylococci and *Diplococcus pneumoniae.*

*Hammerl, H.: Wien. Med. Wschr. 108:629, July 26, 1958.

Condition	No. of Patients	No. Responded To Signemycin®
Abscess, pulmonary	17	16
Bronchiectasis	19	13
Bronchitis	286	267
Bronchopneumonia	192	179
Empyema	12	11
Pneumonia, lobar	150	146
Pneumonia, other febrile	160	150
Various infected pneumopathies	192	172
Totals	1,028	954 (92.8%)

consistently effective...often when others fail

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tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Also available as Syrup, Pediatric Drops, and half-strength Capsules

Brief Summary and Bibliography follow.

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Dr. Ira Myers, state health officer, received a standing ovation from the association following an address on state of the Health Department. Dr. Myers is shown with visual aids which he utilized during his talk.



The Fifty Year Club—doctors who have been practicing for that length of time—was honored along with association past presidents at a breakfast. Some of the group are shown above.



Of 425 patients with confirmed G.I. infections... 387 or 91.1% were treated successfully with Signemycin®

Note:
Loughlin and co-workers* achieved cure (absence of parasites) in all 100 of their patients with *chronic amebic colitis*. Feces became negative in all within the planned ten-day period of Signemycin administration. Upon re-examination of the feces six weeks later, the offending pathogen *(E. histolytica)* had reappeared in only 7 cases.

*Loughlin, E. H. et al.: Antibiot. Med. 7:739, Dec., 1960.

Condition	No. of Patients	No. Responded to Signemycin
Amebiasis	237	222
Cholecystitis and cholangitis	105	97
Enteritis	41	31
Peritonitis	15	14
Various, including pancreatitis, appendicitis and colitis	27	23
Totals	425	387 (91.1%)

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Side Effects: Glossitis and allergic reactions, as well as severe anaphylactoid reactions, have been reported as rare side effects. Should significant reaction or idiosyncrasy occur, discontinue medication and institute countermeasures. Use of tetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. Reduce usual oral dosage and consider serum level determinations in patients with impaired renal function to prevent possible liver toxicity due to excessive accumulation of antibiotic in the serum.

Precautions: Overgrowth of nonsusceptible organisms may occur. In such cases, discontinue medication and institute appropriate specific therapy as indicated by susceptibility testing. Aluminum hydroxide gel given with antibiotics has been shown to decrease their absorption and is contraindicated. The coloring agents used in Signemycin Syrup and Pediatric Drops may produce red discoloration of stools.

Triacetyloleandomycin, a constituent of Signemycin, administered to adults in daily oral doses of 1.0 Gm. (3 Gm. Signemycin) for periods of more than ten days may produce hepatic dysfunction and jaundice. In the rare patient who requires this high dosage level of Signemycin initially, liver function should be carefully followed and dosage should be reduced, as promptly as possible, to the usual recommended range of 1.0 to 2.0 Gm. per day. Therefore, Signemycin is recommended primarily for the treatment of acute or severe infections, with treatment restricted to a ten-day period. If clinical judgment dictates continuation of therapy beyond ten days, serial monitoring of the liver profile should be carried out, including BSP, transaminase, and cephalin flocculation tests. Changes observed in liver function were reversible following discontinuation of the drug.

Formulas: Capsules: 250 mg. Signemycin (167 mg. tetracycline HCl and 83 mg. oleandomycin as triacetyloleandomycin).

Capsules: 125 mg. Signemycin (83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin).

Syrup: 125 mg. Signemycin (tetracycline equivalent to 83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin) per 5 cc.

Pediatric Drops: 100 mg. Signemycin (tetracycline equivalent to 67 mg. tetracycline HCl and 33 mg. oleandomycin as triacetyloleandomycin) per cc.

More detailed professional information available on request.

Science for the world's well-being® Pfizer *Since 1849*

PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc. New York, New York 10017



Of 5,057 patients with confirmed infections of all body systems... 4,731 or 93.5% were treated successfully with Signemycin®

Note:

The high rate of response to Signemycin in these cases is noteworthy because the totals include many patients with difficult-to-treat infections, many whose infections had proved resistant to other agents, and many who had been treatment failures on other therapy.[1-87] In addition the following criteria were used for the cases cited: (1) only published results were used (2) results were confirmed by clinical and/or laboratory findings (3) patients were cured, not "improved" (4) dosage conformed with current recommendations in the United States (5) no other anti-infective agents were used concomitantly (6) no instance of prophylactic use was included in these tabulations.

Condition	No. of Patients	No. Responded To Signemycin
Ear, nose and throat infections	507	465
Respiratory infections	1,028	954
Gastrointestinal infections	425	387
Genitourinary infections	748	684
Skin and soft-tissue infections	1,088	1,036
Bone and joint infections	71	64
Deep-seated or generalized infections	257	251
Obstetrical & gynecological infections	341	320
Miscellaneous conditions	592	570
Totals	5,057	4,731 (93.5%)

consistently effective...often when others fail

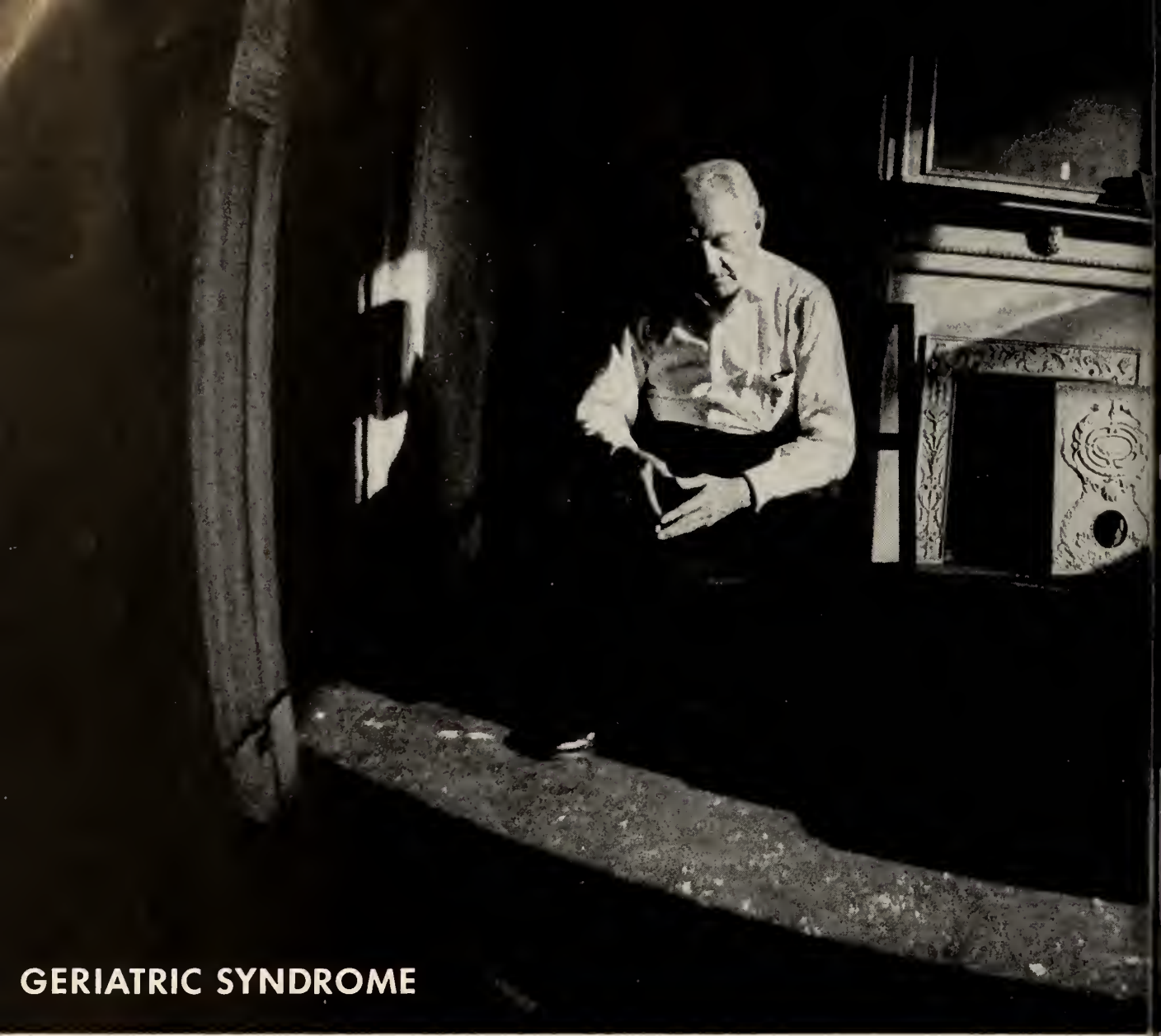
Signemycin®

tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Also available as Syrup, Pediatric Drops, and half-strength Capsules

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GERIATRIC SYNDROME

when a change in environment overwhelms him with anxiety

Failing health, financial difficulties, or the death of a spouse are among the reasons why elderly people may be obliged to leave their familiar surroundings. Moving in with children or entering a home for the aged may satisfy practical requirements but can be psychologically traumatic since emotional resilience tends to diminish with age.

Even when anxiety reaches overwhelming proportions, you can counteract it promptly with the potent tranquilizer—Atarax (hydroxyzine HCl).

The outstanding systemic safety record of Atarax makes it particularly suitable for geriatric patients whose drug tolerance is often low. The usual initial dosage in such patients is 50 mg. q.i.d. However, this tranquilizer is so well tolerated that dosage can be adjusted to meet individual requirements. The wide variety of dosage forms allows flexibility of administration from any standpoint—convenience, patient preference, or emergency requirements.

No age, of course, is exempt from anxiety and any number of circumstances can unleash it. Keep Atarax in mind for *all* your emotionally distressed patients—from under 6 to over 60.

for any age—for any stage of anxiety

ATARAX® (hydroxyzine HCl) tablets syrup parenteral

...In any condition where tissue depletion of the water-soluble vitamins is found, Rx **RoeriBeC**® therapeutic B complex with 500 mg. of vitamin C.

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New York, New York 10017



Side effects and precautions: The transitory drowsiness which may occur with hydroxyzine HCl usually disappears spontaneously in a few days with continued therapy, or is correctable by dosage reduction. Dryness of the mouth may be seen with higher doses. Involuntary motor activity has been reported in hospitalized patients on higher than recommended doses. Hydroxyzine HCl may potentiate CNS depressants, narcotics such as meperidine, barbiturates, and anticoagulants. In conjunctive use, dosage for these drugs should be decreased. Because drowsiness may occur, patients should be cautioned against driving a car or operating dangerous machinery. **Parenteral Solution Precautions and contraindications:** This dosage form is intended only for I.M. or I.V. administration and should not, under any circumstances, be injected subcutaneously or intraarterially. When the usual precautions for I.M. injection have been followed, reports of soft tissue reactions have been rare. I.V. administration should be slow, no faster than 25 mg. per minute, and should not exceed 100 mg. in any single dose. Particular care should be used to insure injection only into intact veins; a few instances of digital gangrene occurring distal to the injection site have been attributed to inadvertent intraarterial injection or periarterial extravasation, both of which should be avoided. **More detailed professional information available on request.**

J. S. Smolian Honored With Gorgas Award

J. S. Smolian, Birmingham philanthropist whose generosity made possible the Smolian Psychiatric Clinic at the University of Alabama Medical Center, has been chosen to receive the medical profession's highest honor, the William Crawford Gorgas Award.

The award is presented annually to a non-medical person who the Association feels has done most to advance the cause of public health in the state during the previous year. It is named for the late Dr. William Crawford Gorgas whose work in conquering malaria and yellow fever brought him world renown.

The doors of the Smolian Clinic were opened in 1960 as a new hope for the nearly-forgotten mentally ill in Alabama. The clinic, named for Mr. and Mrs. Smolian by a special act of the Alabama Legislature, provides outpatient facilities, and a home for the Department of Psychiatry of the Medical College of Alabama, as well as beds for treatment within the clinic.

The clinic was made possible by a number of large cash donations from the Smolians, the money being used to match federal Hill-Burton funds.

While considering the selection for the Gorgas Award, the state association received letters from a large number of influential organizations on behalf of the Smolians, including the University of Alabama, the Jefferson County Medical Society, the University of Alabama Medical Center and many other individual citizens.

Previous recipients of the award are: Senator Lister Hill, 1958, for his work in the field of health legislation; Marc Ray Clement, 1959, for his contribution in the field of tuberculosis; Paul Johnston, 1960, for his work in the mental health field; Frank S. Keeler, 1961, for his contributions in the field of tuberculosis; and Frank E. Spain, 1964, for his contributions and work on behalf of improving health resources in the state.



...and in previously treated hypertensive patients...



Uh-huh.



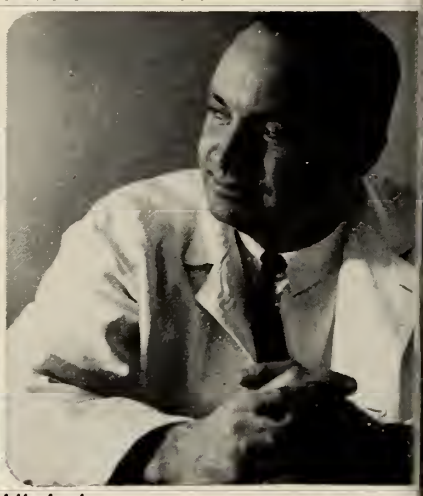
Regroton improved response in 76 out of 80...



Uh-huh.



...reducing mean arterial pressure from 135 to 112 mm. Hg.



Uh-huh.



Don't you even want to try it, Doctor?



I've *already* got eleven patients doing fine on Regroton.



Why didn't you say so in the first place?

Regroton®

Superior to other antihypertensives in 76 of 80 patients in a 2-year study*

Geigy

Composition: Each tablet contains chlorthalidone, 50 mg., and reserpine, 0.25 mg.
Contraindications: History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.
Warning: Discontinue 2 weeks before general anesthesia, 1 week before electroshock therapy, and if depression or peptic ulcer occurs.
Precautions: Reduce dosage of concomitant antihypertensive agents by one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take particular care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.
Side Effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.
For full details, see the complete prescribing information.

Average Dosage: One tablet daily with brea
Availability: Bottles of 100 and 1000 tablets.

*Chupkovich, V.; Finnerty, F. A., Jr., and Kakaviatos, N.: The value of chlorthalidone reserpine in moderately severe and severe tension: A two year study. Presented at the Inter-American Congress of Cardiology, Mc June 14–19, 1964.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York RE-3455



Award time saw Davenport Smith of Birmingham and Virginia Greer of Mobile receive the Douglas L. Cannon Medical Reporter Award. Dr. Glenn, right, is shown with the two recipients in the above photo. Below are Mr. and Mrs. J. S. Smolian who were honored with the association's highest honor, the William Crawford Gorgas Award.



SMITH, MRS. GREER WIN CANNON AWARD

The Medical Association of the State of Alabama has named Mr. Davenport Smith of WBRC-TV in Birmingham and Mrs. Virginia Greer of the Mobile Press-Register as recipients of its 1965 Douglas L. Cannon Medical Reporter Awards.

The award, established to honor Alabama reporters for their accurate and factual reporting of medical news, was named for the late Douglas L. Cannon, M. D., of Montgomery, Alabama.

Dr. Cannon served for 29 years as Editor-in-Chief of *The Journal of the Medical Association of the State of Alabama.*

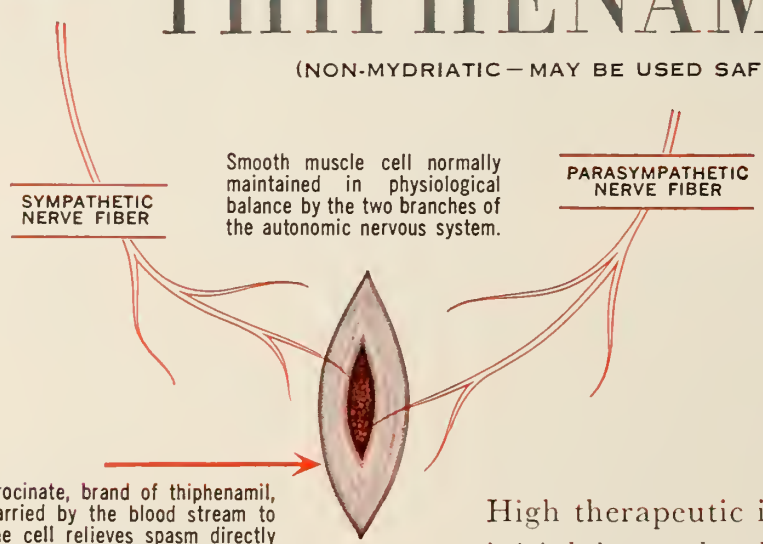
IRRITATIVE DIARRHEA
MUCOUS COLITIS
SPASTIC URETERITIS
DIVERTICULITIS
BLADDER SPASM

. . . relieved by direct musculotropic action with

Trocinate®

BRAND THIPHENAMIL HCL

(NON-MYDRIATIC—MAY BE USED SAFELY IN GLAUCOMA)



Trocinate, brand of thiphenamil, carried by the blood stream to the cell relieves spasm directly without significant interference with the autonomic system.

Each tablet contains 100 milligrams Thiphenamil HCl.

High therapeutic index of Trocinate permits initial dosage level sufficient to relieve spasm promptly. Usual initial dose, 4 tablets, then 2 tablets q.4.h. Maintenance dose, 1 or 2 tablets q.4.h. No serious side-effects have been reported in 13 years of clinical use.

Dispensed in bottles of 100 and 250 tablets

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA

Manufacturers of ethical pharmaceuticals since 1856



Gaiety was the keynote at the annual Scroll & Key Club dinner dance held at the Vestavia Country Club.



Acting as master of ceremonies at the dinner dance was Dr. William E. Lawrence, president of the Jefferson County Medical Society. Also at the head table, with their wives, are Dr. John Paul Jones, Dr. Donald and Dr. Glenn.



The session's scientific sections were well attended and the speakers presented papers on a wide variety of medical subjects. Dr. Champ Lyons, extreme right above, is shown moderating one panel discussion on "New Concepts in the Diagnosis and Treatment of Malignancies." Others shown above, left to right, are Dr. A. Earl Walker of Johns Hopkins, Dr. Robert Roth of the Medical College of Alabama, Dr. Charles M. Huguley of Emory University and Dr. William M. Christopherson of the University of Louisville, who also delivered the Jerome Cochran Lecture.



DR. LEROY VANDAM
Brigham Hospital, Boston



DR. JAMES P. MARR
Women's Hospital of New York



DR. W. M. CHRISTOPHERSON
University of Louisville



Others on the panel, shown above, included, left to right, Dr. William J. Pitts of the Medical College of Alabama, Dr. William H. Hartmann of Johns Hopkins, Dr. David L. Barclay of Tulane University and Dr. David M. Witten of Mayo Clinic.



DR. BRUCE HOLDING
Montgomery



DR. WILLIAM L. GLENN
Yale University



DR. BENJAMIN FELSON
University of Cincinnati



As the photo shows, the hall was packed with attentive medical men.



F. J. Brown, Jr.—Montgomery-Mobile



B. E. Strong—Birmingham



J. H. Butler—Phenix City

"We're puzzled"*...

...why some physicians use synthetic preparations or thyroglobulin

...why some use nonbrand thyroids or write "thyroid U.S.P."

...when ARMOUR THYROID offers so many more advantages

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3. uniform potency—doubly assayed, chemically and biologically
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NEW—for a continuous supply of Armour Thyroid for you or your immediate family simply complete and return this coupon

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¼ gr. ½ gr. 1 gr. 2 gr. 3 gr. 5 gr.

Please circle potency requested.



around the state

JOINT COUNCIL SEEKS TO IMPROVE THE HEALTH CARE OF THE AGED

By J. J. Kirschenfeld, M. D.

The Alabama Joint Council to Improve the Health Care of the Aged was organized in the summer of 1959 along the lines recommended by the National Joint Council to Improve the Health Care of the Aged. The latter organization was initiated through the efforts of the AMA in order to "correlate the efforts and resources of member organizations as the primary purveyors of the health care of the aged and to establish liaison and a cooperative relationship with other organizations working with similar purposes." Both the national and state organizations include representatives of the dental, hospital, medical, nursing home and pharmaceutical associations.

The following goals were formulated for the state councils:

1. To identify and analyze the health needs of the aged
2. To appraise the available health resources for the aged
3. To foster effective methods of payment for the health care of the aged
4. To develop community programs to foster the best possible health care of the aged
5. To promote the health education programs for the aged
6. To inform the public of the facts related to the health care of the aged

The Alabama Joint Council to Improve the Health Care of the Aged, is a loosely knit organization, composed of representatives of the state associations mentioned above. The chairman is the representative of the State Medical Association. Periodic meetings have been held and the council has acted as a clearing house for the various activities on the aging being conducted by the constituent associations. Representatives of the council have participated in the National and Regional Joint Council Conferences.

The Alabama Joint Council also participated in the information gathering activities of the Governor's Advisory Committee on Aging in preparation for the White House Conference on Aging held in 1961.

Through efforts of the constituent associations, definite programs have been established towards recruiting and improving the education of nurses in regards to nursing homes and chronic disease programs. The Joint Council has worked closely with other groups towards improving the number and quality of nursing homes and in general improving the care of the chronically ill aged. Efforts have been made to make dental treatment available for patients in nursing homes and the bedridden at home. Pre-entrance dental examinations upon admission to a nursing home have been recommended. The Joint Council has also recommended the in-

auguration of homemakers' services and home nursing programs for the chronically ill at home.

The Joint Council has kept its member associations informed in regards to implementation of the Kerr-Mills Program in the State of Alabama; it has relayed recommendations from each association to the state agencies involved.

Since its inception, the Joint Council has witnessed remarkable and continuing progress in facilities and programs available to the aged in Alabama. The nursing home program at present has expanded enormously so that the state expenditure for nursing home patients totals approximately $7,000,000.00 per year. The Kerr-Mills Hospitalization Program for the medically indigent and the old age pensioner is currently spending at the rate of 7-8 million dollars per year. It is felt that at the present time any aged individual in the State of Alabama can be admitted to a hospital or nursing home for any type of major illness regardless of financial status.

The Joint Council to Improve the Health Care of the Aged continues to function in its major role as a clearing house and coordinator for the various medical and allied programs for the aging in a conservative and rational manner.

Clarke Medical Society Endorses Health Center

The Clarke County Medical Society recently urged county commissioners to accept an offer from the city of Thomasville to give the county a plot of land to be used for a public health center.

In a letter to the commissioners, the society noted that "the greatest beneficiaries of public health facilities are our less fortunate citizens. Further delays in securing a health center may cause unnecessary pain, suffering and illness among these people.

"It is for these reasons," the letter concluded, "that the Clarke County Medical Society urges you and the Commissioners Court to take advantage of the generous offer made by the City of Thomasville."

COLLEGE OF PHYSICIANS NAMES NINE FELLOWS

The American College of Physicians named nine Alabama doctors as Fellows during the college's Golden Anniversary Session recently at Chicago.

Honored were Dr. Richard Carter, Dr. Hugh J. Dempsey, Dr. H. Joseph Hughes, Dr. Bruce K. Johnson, Dr. Alwyn A. Shugerman, Dr. Robert H. Yoe, all of the Alabama Medical College faculty, Dr. H. Hamilton Hutchinson of Montgomery and Dr. William H. Tucker and Dr. Earl B. Wert, both of Mobile.

Dr. Herlihy Guest Speaker At Livingston Newman Club

Dr. Charles E. Herlihy, associate professor of psychiatry at the University of Alabama School of Medicine, was a recent guest speaker at the Newman Club at Livingston State College.

Dr. Newman spoke to the students on the proper sense of values to be considered when contemplating marriage.

Psychiatrist Now Working With Court Officials

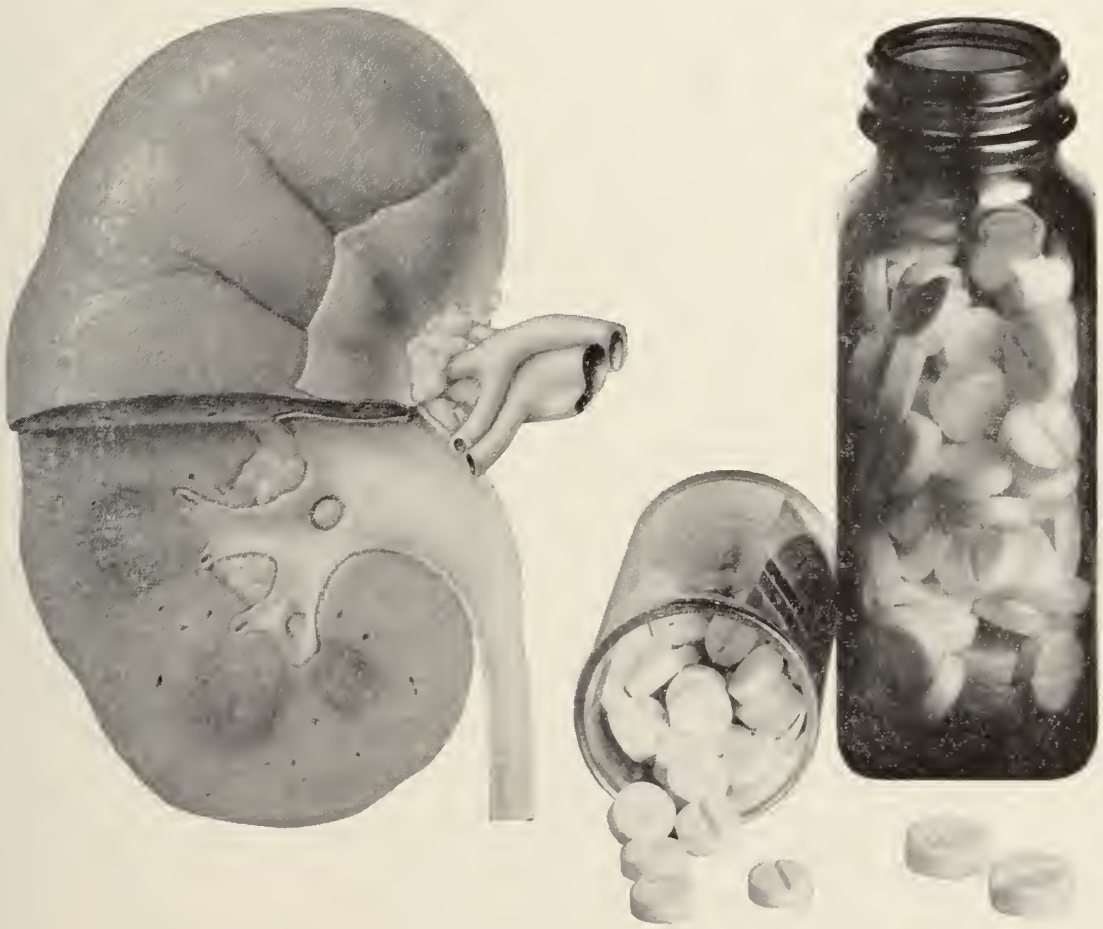
The medical profession has joined hands with the bench in Jefferson County's Juvenile and Domestic Relations Courts.

Dr. Robert Estock, resident in psychiatry at the University of Alabama Medical Center, visits the court once a week to assist disturbed children and to lend advice to court officials. The program is sponsored by the Psychiatry Department of the Medical College.

Dr. Chenoweth Participates On 'Indigent Sick' Panel

Dr. Arthur I. Chenoweth of Birmingham recently represented the medical profession at a panel discussion on the needs of the indigent sponsored by the Jefferson County Health Council.

at Merck Sharp & Dohme...



understanding... precedes development

The development of chlorothiazide and probenecid were events of major importance, but perhaps even more important for the future was the Renal Research Program by which they were developed. When Merck Sharp & Dohme organized this program in 1943, it was expressing in action some of its basic beliefs about research:

• Many problems connected with renal structure and function were still undefined or unsolved. The Renal Research Program would begin its basic research in some of these problem areas.

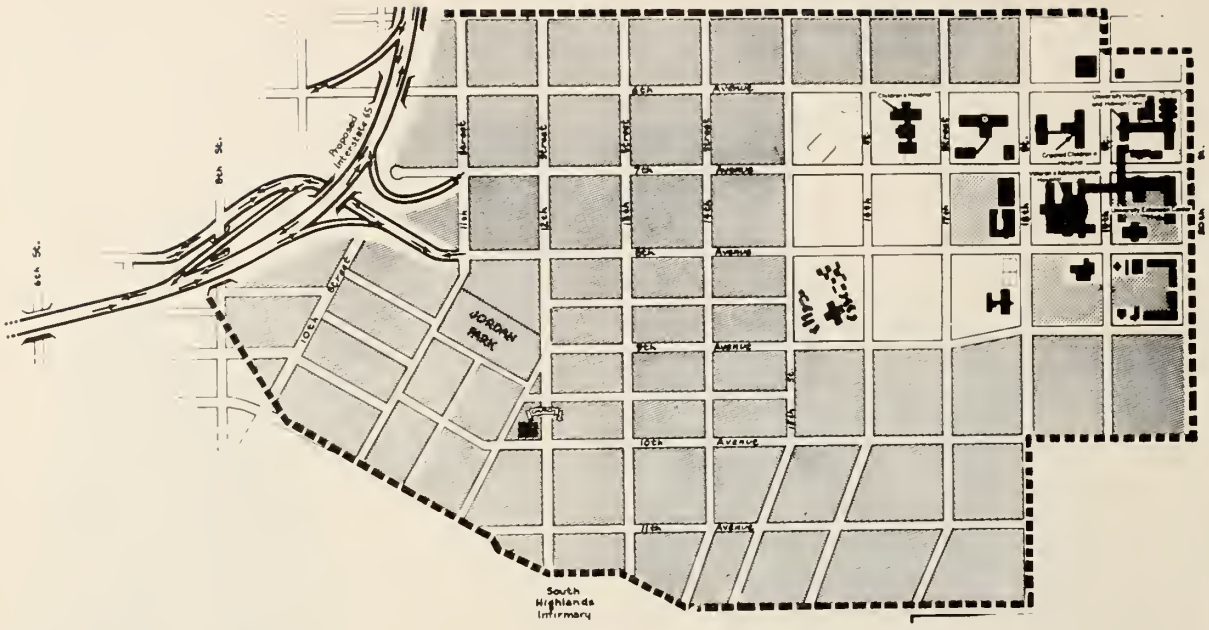
• From knowledge thus acquired might come clues to the development of new therapeutic agents of significant value to the physician.

For example, the Renal Research Program put fifteen years into this search before chlorothiazide became available. But because these years had first led to a greater understanding of basic problems, the desired criteria for chlorothiazide existed before the drug was developed.

Along with other research teams at Merck Sharp & Dohme, the Renal Research Program continues to add new understanding of basic problems—understanding which will lead to important new therapeutic agents.

MSD MERCK SHARP & DOHME Division of Merck & Co., Inc., West Point, Pa.

where today's theory is tomorrow's therapy



TO TRIPLE IN SIZE

Funds Asked For Expanded Medical Center

The Birmingham City Council recently authorized the Birmingham District Housing Authority to apply for funds to conduct a survey to consider a 45-block expansion of the present 15-block Medical Center in Birmingham.

The Council action was taken as a result of action by the 136-member Mayor's Committee for the Medical Center.

After hearing reports on the past and future of the Medical Center, economic effects of the center's annual $30 million budget, and a detailed explanation of the urban renewal program, the committee unanimously approved a resolution requesting the city to take the initial step in the expansion program.

Medical College Doctors Address Oral Surgeons

Two members of the faculty of the Medical College of Alabama recently addressed a gathering of oral surgeons from the Southeast at a meeting in Birmingham.

Speaking to the group were Dr. Champ Lyons, professor and chairman of the Department of Surgery of the college, and Dr. J. Garber Galbraith, professor of surgery.

The Conference was conducted by Dr. Leonard H. Robinson, professor of dentistry at the University School of Dentistry and associate professor of pathology at the Medical Center.

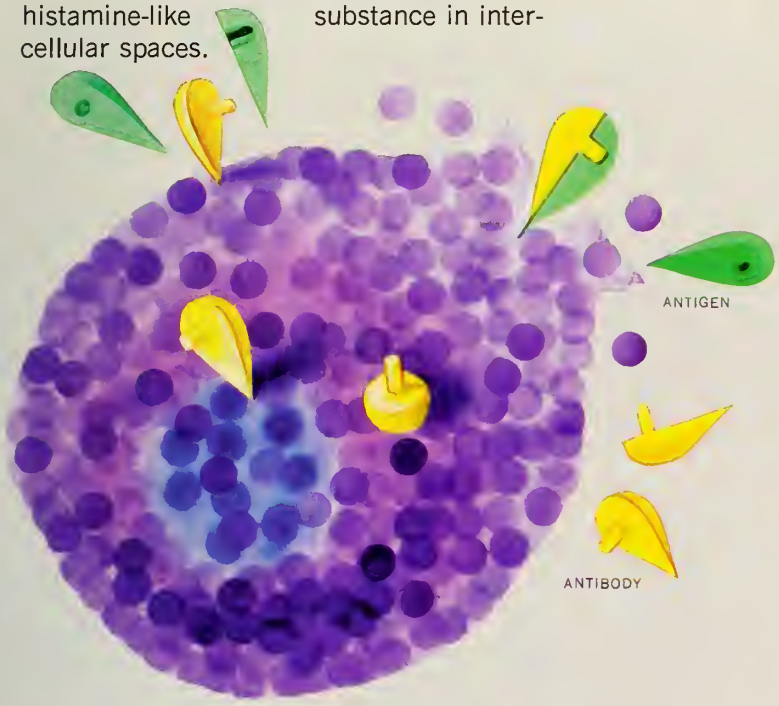
Dr. John Dossett Awarded Residency Fellowship

Dr. John H. Dossett of Eight Mile, Ala., has been granted a two-year residency Fellowship in pediatrics by the Wyeth Fund for Postgraduate Medical Education. Dr. Dossett will study at the University of Minnesota Hospitals in Minneapolis.

Dr. Dossett is one of 15 physicians awarded fellowships this year by the Wyeth Fund which was established in 1958 by Wyeth Laboratories, pharmaceutical antibiotic and infant formula manufacturers.

in theory, allergy begins like this:

When antigens invade the body, antibodies, formed chiefly by plasma cells, may become attached to mast cells. If the same antigen reappears and reacts with the antibodies, the mast cell disrupts (as pictured below). Subsequently, the "exploding" mast cell deposits granules of bound histamine or histamine-like substance in intercellular spaces.



in allergy, Dimetane® Extentabs®

(brompheniramine maleate, 8 mg. & 12 mg.)

work with no more sedation than placebo*

Although the mechanisms of allergy are still theoretical, the response to Dimetane (brompheniramine maleate) is ample proof that a good antihistamine can, and does, work—and (as reported in one investigation*) with no more sedation than placebo. Dimetane (brompheniramine maleate) assures your allergy patients prompt relief of symptoms while usually permitting them to lead active, alert lives. And a single Extentab provides continuous action for up to 10-12 hours.

*Schiller, I.W. and Lowell, F.C.: New England J. Med. *261*:478, 1959.

BRIEF SUMMARY: *Contraindications:* Hypersensitivity to antihistamines. Not recommended for use during pregnancy. *Precautions:* Until response is determined, patient should be cautioned against engaging in mechanical operations requiring alertness. *Side Effects:* Hypersensitivity reactions, including skin rashes, urticaria, hypotension, and thrombocytopenia have been reported rarely. Occasional transitory drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered. *Other dosage forms available:* conventional tablets (4 mg.); Elixir (2 mg./5 cc.); Injectable (10 mg./cc. ampuls, and 100 mg./cc. in 2 cc. vials).

A. H. ROBINS CO., INC.
Richmond, Virginia 23220



Robins
PHARMACEUTICALS | RESEARCH

basic therapy in low-back pain: bed, board, heat

Whether low-back pain is in the chronic or acute phase, the appropriateness of bed rest for such a patient is beyond controversy. Boards placed under the mattress, for a firmer bed to further immobilize the spine, are another common recommendation. And most investigators consider heat beneficial—moist heat in particular.[1-5]



and Robaxin®-750

(methocarbamol 750 mg.)

(CAPSULE-SHAPED TABLETS)



It has been noted that low-back disorders frequently "...are caused by truly mechanical conditions which yield to conservative treatment."[1] Basic to this conservative treatment are bed rest, a board for the bed, and applied heat. In addition, a good muscle relaxant is often helpful, as "...muscle relaxants are useful in chronic as well as acute low backaches."[4]

Robaxin (methocarbamol) has relieved spasm and pain in cases where the patient "had not responded to conservative measures prior to drug therapy."[6] A 100-patient study showed that Robaxin provided greater relief of muscle spasm for a longer period of time without adverse reactions "than any other commonly used relaxants...."[6]

A well-tolerated[7] skeletal muscle relaxant with "specificity of action,"[7] methocarbamol leaves normal muscle tone unaffected. Moreover, there is little likelihood of sedation[7]—a considerable advantage for the patient who must remain active and alert on his job.

Significantly, clinicians advise using a muscle relaxant "early and in adequate dosage."[8] In this regard, Robaxin (methocarbamol)—*particularly in the 750 mg. dosage (2 tabs. q.i.d.)*—offers optimal therapeutic benefits without a significantly increased incidence of side effects. And just as it works well as part of the basic regimen for low-back pain, so also does Robaxin (methocarbamol) often provide muscle relaxation in such conditions as musculoskeletal injury, chronic neurological disorders, and orthopedic situations.

BRIEF SUMMARY—Robaxin (methocarbamol) Tablets: Contraindicated in hypersensitive patients. Side effects (light-headedness, dizziness, drowsiness, nausea) may occur rarely, but usually disappear on reduced dosage. Hypersensitivity reactions develop infrequently.

ALSO AVAILABLE: Robaxin® Tablets (methocarbamol, 500 mg.) Robaxin Injectable (methocarbamol, 1 Gm./10 cc.)
Robaxisal® (methocarbamol with aspirin) and Robaxisal-PH Tablets (methocarbamol with Phenaphen®).

REFERENCES: 1. Soto-Hall, R.: Med. Sci. *14*:23, 1963. 2. McCarrol, H.R.: Paper read at the Annual Meeting of the American Medical Association, Atlantic City, June 16-20, 1963. See Medical News: J.A.M.A. *185*:39 (July 13), 1963. 3. Gordon, E.J.: Med. World News *5*:54, 1964. 4. Cozen, L.: GP *26*:82, 1962. 5. Larson, C.B.: Postgrad. Med. *26*:142, 1959. 6. Forsyth, H.F.: J.A.M.A. *167*:163, 1958. 7. Weiss, M., and Weiss, S.: J. Amer. Osteopath. Ass. *62*:142, 1962. 8. Rowe, M.L.: J. Occup. Med. *2*:219, 1960.

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PHARMACEUTICALS | RESEARCH



ALABAMIANS ATTEND RURAL HEALTH MEETING

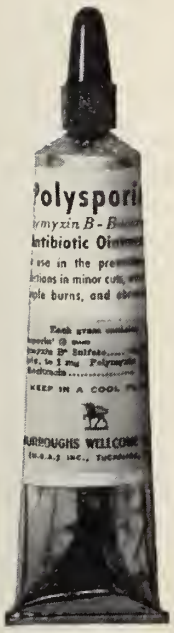
A number of Alabamians, including Emmett Wyatt of the Medical Association of the State of Alabama's Montgomery staff, recently attended the 18th National Rural Health Conference in Miami Beach. The conference is sponsored by the American Medical Association. Four state doctors are shown above attending a meeting on the Committee of Maternal and Child Health. They are, left to right, Dr. Gilder L. Wideman of Birmingham, Dr. James H. French of Montgomery, State Health Officer Dr. Ira Myers and Dr. Harold Klinger of Montgomery.

Also in attendance, below left, were Miss Fariss Prickett of the Auburn University Extension Service, Dr. John D. Rayfield of Sylacauga and Mrs. Mary E. Coleman of the Auburn Extension Service. Shown below right are Dr. Francis T. Holland of Tallahassee, Florida, a member of the AMA Council on Rural Health, Dr. Rayfield, who is Talladega County Health Officer, and Dr. Ben N. Saltzman of Mountain Home, Ark., also a member of the Council on Rural Health.





in treating topical infections, no need to sensitize the patient



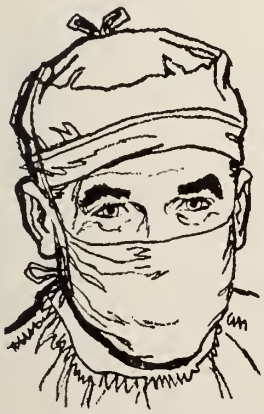
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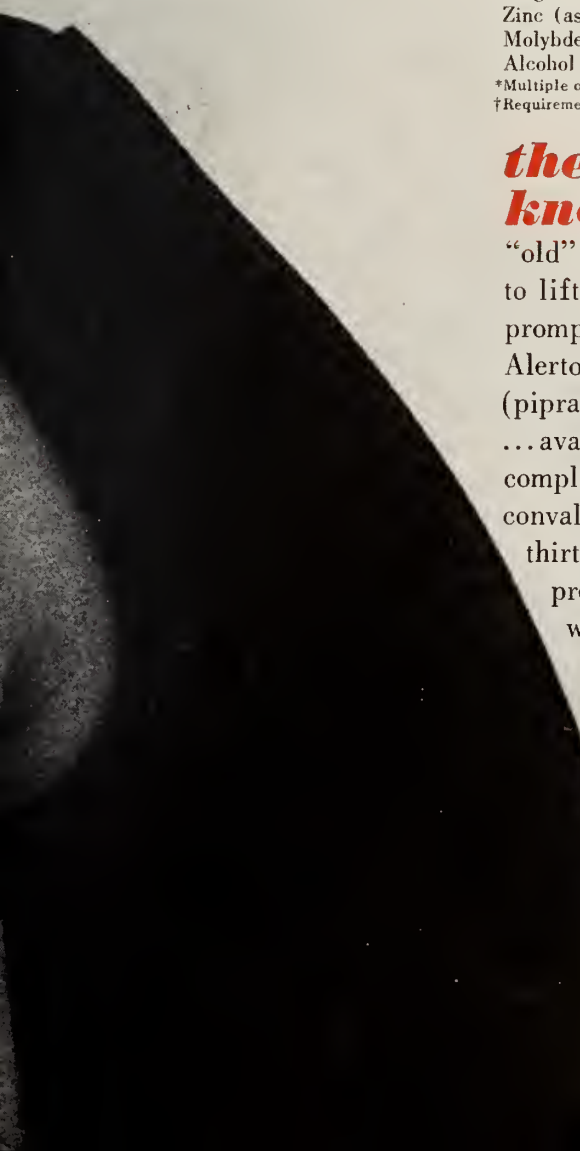
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Calcium glycerophosphate	(2% MDR for calcium and phosphorus)	100 mg.
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Manganese (as sulfate)		1 mg.
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Convention Calendar

AMERICAN COLLEGE OF PHYSICIANS

May 10-14, New York University Medical Center, New York, N. Y., Postgraduate Course No. 14, Rehabilitation, Howard A. Rusk, M. D., director.

* * *

AMERICAN COLLEGE OF PHYSICIANS

May 24-26, Royal Victoria Hospital, Montreal, Canada, Postgraduate Course No. 15, Current Concepts In Gastroenterology, Richard D. McKenna, M. D., director.

* * *

CHILDREN'S HOSPITAL OF PHILADELPHIA

May 24-28, Philadelphia, Pa., Five-Day Refresher Course in Pediatrics, curriculum consisting of lectures and clinics by members of the faculty staff.

AMERICAN COLLEGE OF PHYSICIANS
(Postgraduate Course No. 16)

June 7-11, University of Iowa, Iowa City, Iowa. Purpose of the course is to review developments and newer concepts of disease in Internal Medicine for the practicing internist. The major subspecialties of Internal Medicine will be included.

* * *

AMERICAN COLLEGE OF PHYSICIANS
(Postgraduate Course No. 17)

June 9-11, New York University Medical Center, New York, N. Y. Course is entitled, "The Hemodynamic Basis For Auscultation" with emphasis placed on the mechanisms of production of heart sounds and murmurs and the correlation with pressure-time variables in the various chambers of the heart.

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is a private psychiatric hospital established in 1925 for the treatment of nervous or mental disorders, alcohol or drug addiction problems.

The hospital accepts both men and women. It is departmentalized according to sex and the degree of illness, with different sections for the acutely ill patient, the mildly ill patient, the convalescent patient, and the chronically ill resident patient. All rooms are private.

HILL CREST SANITARIUM *is a member of*:

American Hospital Association
American Psychiatric Association
National Association of Private Psychiatric Hospitals
Alabama Hospital Association
Birmingham Regional Hospital Council

AMERICAN CANCER SOCIETY
(1965 Scientific Session)

June 16, Drake Hotel, Philadelphia, Pa. Course entitled "Hormones and Chemotherapy for Cancer—A Critical Appraisal."

* * *

AMERICAN COLLEGE OF CHEST PHYSICIANS

June 17-21, Waldorf Astoria Hotel, New York, N. Y. Scientific program under the chairmanship of Dr. David P. Boyd, Boston, Mass.

* * *

AMERICAN MEDICAL ASSOCIATION

June 20-24, New York Coliseum, New York, N. Y. Annual convention.

DR. C. T. HAYES

Dr. C. T. Hayes, who had practiced medicine in Elba for more than 50 years, died March 9 in an Elba hospital. He was 81. A native of Longstreet, Ala., Dr. Hayes practiced medicine in Enterprise before moving to Elba. Survivors include a son, C. T. Hayes, Jr., of Elba.

Dr. Gipson Joins Staff At Partlow State School

Dr. Amos C. Gipson has joined the staff at Partlow State School and Hospital, according to a recent announcement by Dr. J. S. Tarwater, superintendent of Alabama State Hospitals.

A native of Fyffe, Dr. Gipson has been in private practice of pediatrics at Gadsden for the past 34 years.

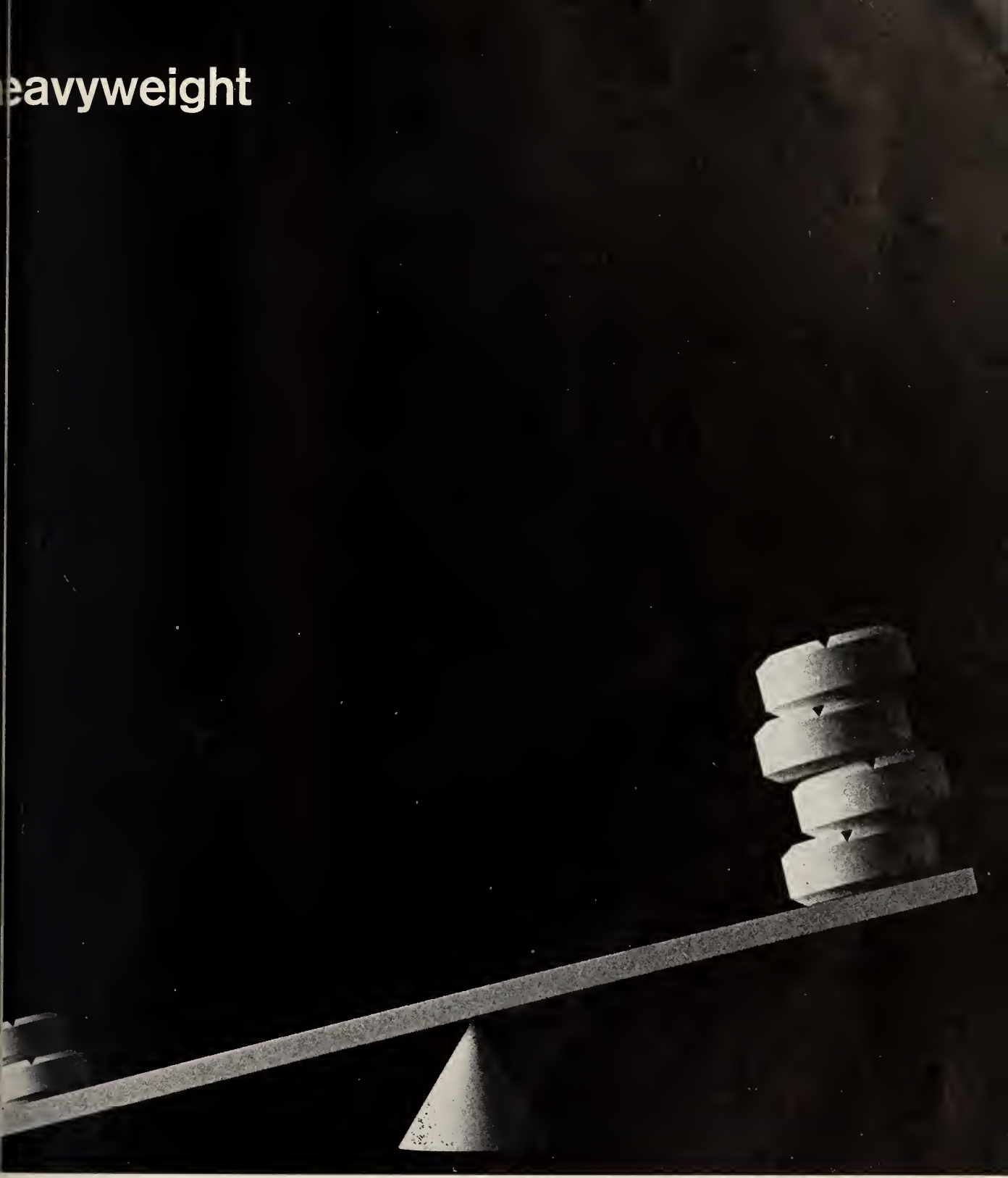
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*Swartz, C., et al.: Circulation 28:1042, 1963.

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The Woman's Auxiliary



It is with deep gratitude and humility that I accept this honor—*grateful* for the privilege of being able to serve this wonderful organization as president and *humble* when I realize that I am to occupy the chair as chief of this group where so many outstanding executives have preceded me. I intend to give *my best* and will expect the same from all of you. I believe, too, that I speak for the officers and committee chairmen when I say that all of us will uphold the highest ideals and standards for which this auxiliary has stood throughout the years.

Just as progress has been made in scientific fields of medicine, so has our auxiliary made progress. This is due in large part to the combined efforts of all those who have served this group loyally and faithfully in their various capacities. Also, we have had tremendous help from our national headquarters through their various handbooks for guidance, bulletins and comparative records of other states' activities.

What are we actually *doing* to *justify* our existence? What is our purpose and program to assist our husbands in their objectives both as physicians to the sick and worthy citizens of the community? We are our husbands' *trademarks!* We can help or we can hinder. The eyes of the community are on us, the wives, as well as our noble mates. At times we are called upon to defend and clarify certain medical issues when the truth would be distorted by the misinformed and prejudiced. We are compelled to speak out when, in our opinion, certain political actions are *not* for the best interest of the public as well as our medical profession. I refer specifically to the recently passed Medicare Bill and other such measures which are leading us steadily and surely into the doldrums of socialized medicine. On such issues, we *have* spoken out and *will continue* to do so, along with our husbands, in the future!

Our objective work has embraced many health activities. In particular, I would mention our part in the recent polio drive. Also, our efforts to inform the public in health education through various channels of communication such as TV and radio and the many bulletins published.

The world is faced with numerous problems today. There is the Russian problem, Viet Nam, socialism, the racial situation. They all loom large on the horizon. We can always look for problems too on a national and local basis. Undoubtedly, there will arise difficult situations in our own organization, both statewise and countywise. With understanding, tolerance, hard work and cooperation, however, I believe we can overcome any obstacles which confront us.

One of our chief aims is to *increase our membership* by proper motivation of those counties which have not responded fully. We must give them *desire* and *purpose* for serving. Also, we must continue to stimulate those who have been loyal members throughout the years. Our program must be such that those in our membership will be eager and willing to serve in any capacity called upon.

All of us have much to learn. We intend to progress further by attendance at our various district meetings and through the Fall Board Meeting and conferences. There is no county in the state which cannot profit by the progressive hints given in these meetings.

Firm emphasis is to be placed this year on forwarding the various paramedical careers offered in this area. Needless to say, all of us recognize the grave problem of shortage in technical help for our doctors. There are

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Prolixin is a dependable tranquilizer that provides your patient with low cost therapy. No other tranquilizer costs less. Safe and convenient for office use—Prolixin in a single daily dose provides prolonged and sustained action. Markedly low in toxicity and virtually free from usual sedative effects —Prolixin is indicated for patients who must be alert. Clinical experience indicates fluphenazine hydrochloride is especially effective in controlling the symptoms of anxiety and tension complicating somatic disorders such as premenstrual tension, menopause, or hypertension—also useful for anxiety and tension due to environmental or emotional stress. When you prescribe Prolixin you offer your patient effective tranquilization that is low in cost, low in dosage and low in sedative activity.

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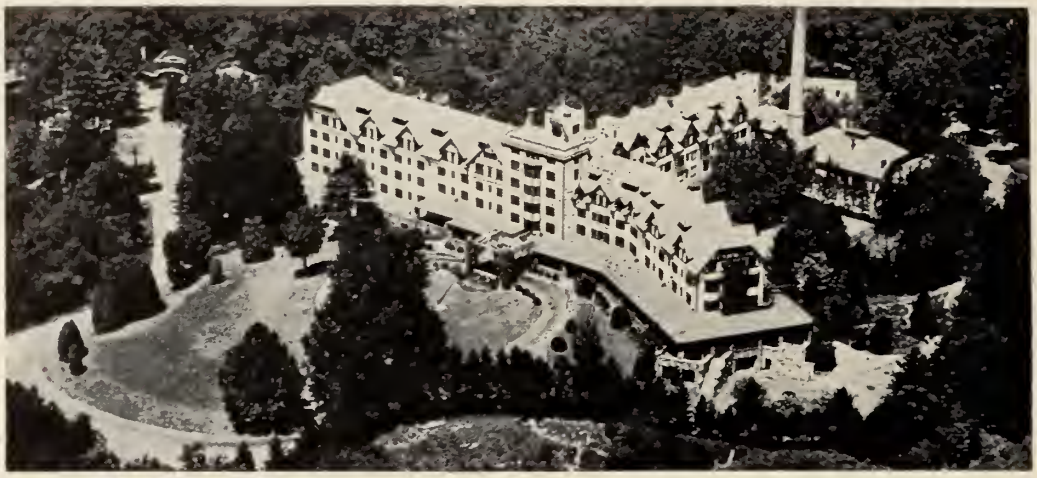
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standing many wonderful structures throughout our state that are only partially occupied because of the lack of doctor assistants. We must carry out a vigorous program of education in these fields in order to attract more personnel and capable assistants. The need for medical technologists, x-ray technologists, nurses, dieticians and occupational therapists is well known to us all.

It is my hope and dream that the coming year will be one of the finest in the history of the Woman's Auxiliary to the medical profession. With your hard work, great desire, full cooperation and prayers, this can be accomplished. And finally, when our years work is done and evaluated, may our predecessors and followers and, in particular, our husbands be able to say "they, indeed, were good trademarks."

Mrs. J. F. Crenshaw

NURSE-LIAISON GUIDES AVAILABLE

The American Medical Association's Committee on Nursing has developed a series of guides for state and county medical societies interested in initiating or revising programs of nurse-liaison activities.

According to Florence M. Alexander, Ph. D., committee secretary, the guides are designed to:

—Assist new committees to organize.

—Strengthen committees already established.

—Present suggestions for expansion of existing committees.

Dr. Alexander said, "Close collaboration of physicians and nurses on matters concerned with the quality of patient care is an essential ingredient to the health care of the people."

Copies of the guides may be obtained by writing the Department of Nursing, American Medical Association, 535 North Dearborn, Chicago, Illinois 60610.

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Thomas S. Hosty, Ph.D., Director

March 1965

Examinations for intestinal parasites	2,023
Typhoid cultures (blood, feces, urine and other)	222
Examinations for gonococci	1,970
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Darkfield Examinations	6
Agglutination tests	8
Examinations for diphtheria bacilli and vincent's	73
Complement Fixation	74
Examinations for Negri bodies (smears and animal inoculations)	260
Water Examinations	2,197
Milk and dairy products examinations	3,945
Examinations for tubercle bacilli	4,213
Miscellaneous examinations	7,949
Total	49,134

BUREAU OF PREVENTABLE DISEASES

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CURRENT MORBIDITY STATISTICS

1965

	Feb.	Mar.	*E. E. Mar.
Tuberculosis	119	118	154
Syphilis	166	171	126
Gonorrhea	254	236	301
Chancroid	2	2	3
Typhoid fever	0	0	0
Undulant fever	0	1	0
Amebic dysentery	1	5	5
Scarlet fever & strep. throat	243	283	271
Diphtheria	2	2	2
Whooping cough	2	3	15
Meningitis	3	3	7
Tularemia	0	0	0
Tetanus	2	1	1
Poliomyelitis	0	0	0
Encephalitis	0	0	0
Smallpox	0	0	0
Measles	435	569	628
Chickenpox	124	193	247
Mumps	32	40	186
Infectious hepatitis	48	31	44
Typhus fever	0	0	0
Malaria	0	0	0
Cancer	587	1,032	599
Pellagra	2	1	0
Rheumatic fever	10	14	17
Rheumatic heart	31	22	31
Influenza	2,987	20,904	796
Pneumonia	361	505	285
Rabies—Human cases	0	0	0
Pos. animal heads	1	1	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

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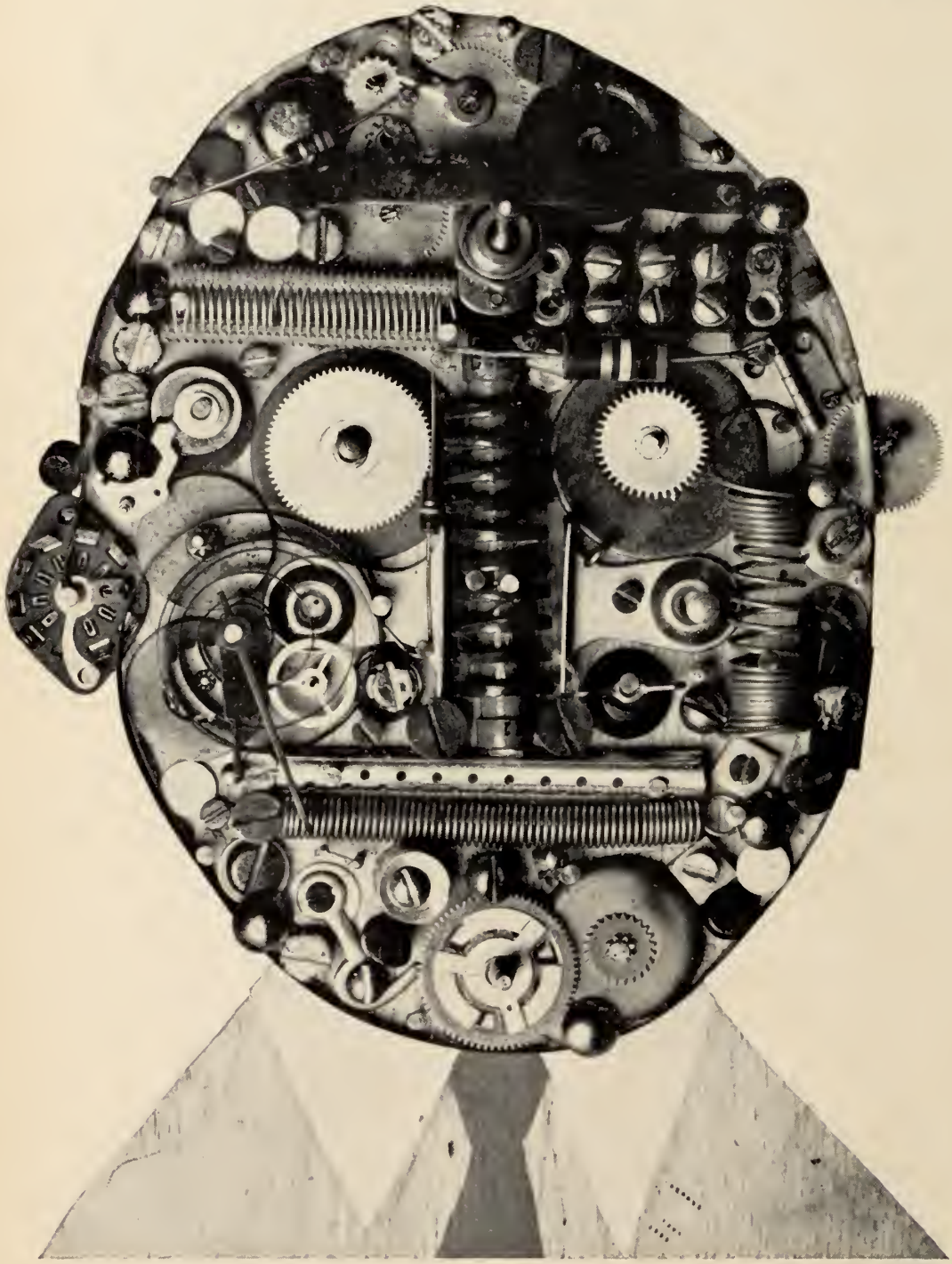
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No untoward side effects have been reported in 12 years of clinical use.

Literature on indications and dosage available on request.

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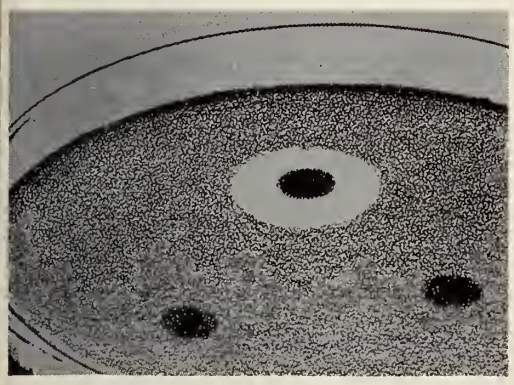
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References: (1) Carroll, G.: Urologists' Letter Club, June 1, 1964. (2) McDonald, D. F., and Short, H. B.: Address to the Fourth Interscience Conference on Antimicrobial Agents and Chemotherapy, New York, Oct. 26-28, 1964.

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Ducks Can Be Dangerous

By Forest E. Ludden, Director

Division of Health Education and Information

Alabama Department of Public Health

A stuffed toy duck submitted to the Alabama Department of Public Health for inspection by a local department store was recently found to be contaminated by Salmonella Give.

The duck was one from a large shipment of novelty products known in the trade as natural chicks and natural ducks. These are chick and duck skins stuffed with artificial material and sold for inclusion in Easter baskets. These items are imported from Japan and/or Germany and distributed throughout the country. The ducks in the Montgomery store were bought from an import firm in Massachusetts.

A department store clerk first contacted the Montgomery County Health Department concerning the safety of the toy ducks because of their rank odor. When the State Health Department was notified of the possibility of a problem, one of the ducks was sent to Dr. C. J. Rehling, state toxicologist, for analysis to determine if the toy ducks were harmful to young children. In the meantime the department store was advised to hold the ducks off the shelf until there was a report from the tests being made.

The state toxicologist reported that the toy duck had the skin and first feathers of a recently hatched duckling, including the bill and the feet and legs. The dried skin had been stuffed with cotton waste material but was impregnated with a mixture of naphthalene and a chlorinated hydrocarbon insecticide, benzenehexachloride, commonly sold for agricultural purposes under the name of Lindane. The benzenehexachloride is a rather potent substance and poisonous to the higher animals as well as insects. If a child put some of the stuffing material in his mouth, the benzenehexachloride would constitute a danger.

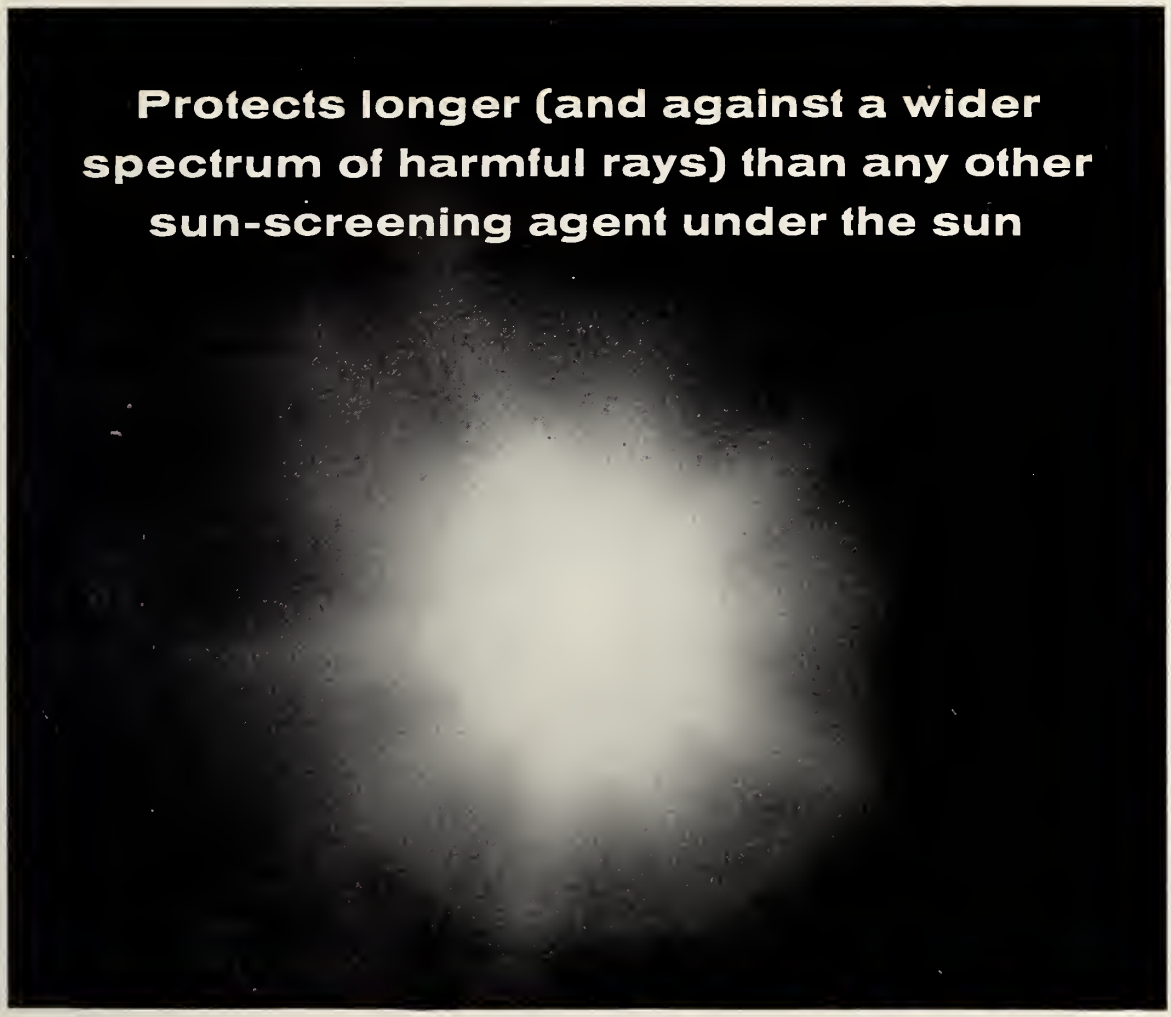
The State Health Department also contacted the Food and Drug Administration in New Orleans, but that agency has no jurisdiction over items not food, drink, or cosmetic. Imports of bulk shipments of stuffed ducklings or chicks, as such, may not be subject to the requirements of either the Federal Food, Drug, and Cosmetic Act or the Federal Hazardous Substances Labeling Act. However, the Food and Drug Administration is investigating the possibility that toy ducks or chicks may be included in Easter candy packages, or may in other ways present health hazards through association with products within their jurisdiction.

While the duck was being tested, a telegram came to the State Health Department from the Communicable Disease Center in Atlanta. The telegram indicated that salmonella organisms had been recovered in the Pennsylvania State Health Department laboratory from 5 out of 7 samples of skins from both natural chicks and natural ducks.

Reports of the findings of the state toxicologist and the communications with the Communicable Disease Center were sent to the department stores involved and to all county health officers so they would be aware of the problem and could be on the lookout for the contaminated ducks in their areas.

Before every holiday there are many novelties which appear on the store shelves to attract the holiday buyer. Some of these novelties may be extremely harmful to children. The consumer is unaware of these hazards. Because of our existing structure it is most difficult to run necessary tests and get results before the holiday season has passed. It is hoped that material such as this will alert physicians and others in the health field to be on guard against harmful novelties.

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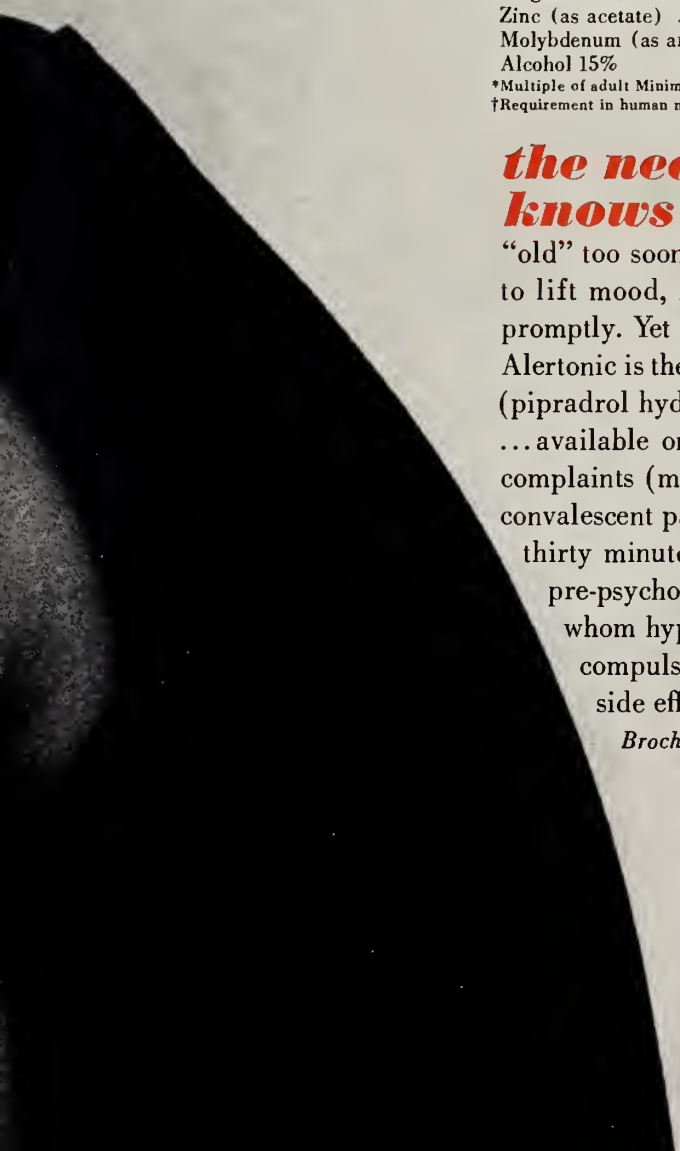
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Cancer Of The Breast

by John L. Carmichael, M. D.

Birmingham, Alabama

One hears expressed rather frequently, pessimistic opinion as to the curability of breast cancer. These expressions are more likely to come from the internist than from other specialists. One such expression recently couched in the form of the question, "Why do a radical operation for cancer of the breast since the disease is rarely ever cured," stimulated me to review a part of my own cases. The series is admittedly too small to be statistically important. However, it is comprised only of personal cases and those arising only in private practice. For these reasons, the analysis of this group of cases may be a little more than usually meaningful for those physicians interested in the treatment of breast cancer.

Several aspects of the problem of breast cancer were considered in analyzing these cases. Some comparison will be made with other series. Several aspects of treatment of this malignancy will also be discussed briefly.

In the period of time under review, 498 operations were done. Multiple incisions in the same, or in both breasts if done at the same time, were considered as one operation. Operations done on the same patient if done at different times were considered as separate operations. Sixty of the 498 operations revealed cancer. Table I compares this incidence of cancer in total breast operations to that of two other series.

TABLE I

SERIES	
McLaughlin, Et Als	
Total Operated Breast Cases	923
Total Cancers	250
Parsons	
Total Operated Breast Cases	336
Total Cancers	76
Author	
Total Operated Breast Cases	498
Total Cancers	60

Of the 60 cases of cancer operated upon, only 56 were operated upon with the hope of cure, i.e. only 56 were considered operable. The age incidence in the series of 56 is indicated in Table II.

TABLE II

AGE: CURATIVE RADICALS

20-29	1	60-69	15
30-39	5	70-79	6
40-49	17	80-89	2
50-59	10		

Table III gives a brief analysis of the 498 cases including the 60 carcinomas of the breast and one other case which was submitted to radical mastectomy because of mistaken diagnosis on frozen section. There was no operative mortality nor any excessive operative morbidity. Only four of the curative radical operations were on colored patients.

In the 60 cases, 28 were noted to be in the left breast and 30 in the right breast. The site of the lesion was not recorded in two. The quadrant of the breast affected was as

TABLE III

Total Breasts Operated		498
Total Rad. (curative)		56
With Axill. Metast.	28	
W/out Axill. Metast.	28	
Radical for Palliation		1
Radical for Granuloma		1
Simple		1
Biopsy-Supraclav. nodes		2

recorded in Table IV. The middle quadrant lesions are those lesions occurring in two adjacent quadrants where the quadrants are formed in the conventional manner by vertical and horizontal lines through the nipple.

TABLE IV

Location of Lesion

Left 28 Right 30

QUADRANTS

Upper Outer 25	Inner Upper 3	Upper Middle 5
Lower Outer 7	Inner Lower 5	Lower Middle 1
Middle Outer 4	Inner Middle 2	Not Noted 8

Forty-four of these 56 cases had been operated on for five or more years, and 34 had been operated on for ten or more years. The cure rate (survival without evidence of disease) in those groups is indicated in Table V.

TABLE V

LIVING & WELL		
5 Yr. or more Postoperative	24	57.1%
Lost to Follow-up	2	
Dead—other causes	3	
Dead—Cancer	13	30.9%
LIVING & WELL		
10 Yr. or more Postoperative	14	41.2%
Lost to Follow-up	2	
Dead—other causes	3	
Dead—Cancer	15	44.1%

Of these 56 cases, 28 had axillary metastases and 28 were without axillary metastases. Of the 28 cases with axillary metastases, only 24 had been operated upon for five years or more and only 16 cases, ten years or more. Of 28 cases without axillary metastases, only 19 had been operated upon for five or more years and only 14 for ten or more years. The five and ten year cure (survival) rate for these groups is indicated in Tables VI and VII.

Urban[1] states that in the last 50 years the salvage rate of primary operable cancer of the breast has almost doubled, 55 per cent now as compared to 28.9 per cent reported

TABLE VI

PATIENTS WITH AXILLARY METASTASES

Living and well (5 yr.)	8	33.3%
Lost to follow-up	2	
Dead—Other Causes	1	
Dead—Cancer	13	30.9%
Living and Well (10 yr.)	4	25 %
Lost to follow-up	1	
Dead—Cancer	11	68.7%

TABLE VII

PATIENTS WITHOUT AXILLARY METASTASES

Living and Well (5 yr. or more)	16	84.2%
Dead—other causes	2	10.5%
Dead—Cancer	1	5.3%
Living and Well (10 yr. or more)	11	78.6%
Dead—other causes	2	14.3%
Dead—Cancer	1	7.1%

by Halstead in 1907. This appears to have been due chiefly to finding lesions early.

There are many undecided questions in regard to treatment of breast cancer. Some of these are minor questions and relate only to adjuvant therapy. The major question has to do with whether the primary treatment shall be surgical or radiological. The radical Halstead type of mastectomy is attacked by those who would use more limited surgery as the primary treatment and then use radiation if at all in a half-hearted way. In this group would be placed also, those who think that it might be wise to preserve the regional nodes for their immunologic defense against the cancer. On the other hand, the radical operation is attacked by those such as McWhirter who would use radiation as the primary treatment and surgery only as an adjuvant to make irradiation more effective. A randomized study of this question has not been done and it would seem that no authoritative answer can be given to it otherwise. It can safely be said that the consensus still is that radical surgery as the primary treatment is as effective and likely more effective than any other treatment designed for cure of cancer of the breast. The type of treatment that McWhirter recommends, with its extensive use of irradiation, would seem to be more devastating to the general health of the patient than the Halstead type of radical surgery.

McWhirter[2] reports on 2507 cases with 43 per cent five year and 26 per cent ten year

survival. When these are age corrected, the figures are 51 per cent five years and 36 per cent, ten year survivals. If they are corrected for operability, there are 58 per cent five years and 39 per cent ten year survivals.

TABLE VIII

1882 Cases 1941-1947, Cases later added to total 2507

	5 Yr.	10 Yr.
Gross	43%	26%
Age Corr.	51%	36%
Oper. Corr.	58%	39%

Another question of some importance is the place of the supra radical mastectomy. This includes enbloc dissection of the internal mammary chain of nodes. Not enough work has been done to evaluate this extension of the radical mastectomy. However, Urban[3] estimates that the five year survival rate clinically free of disease has been increased about ten per cent by such extension.

There has been some question as to the real significance of survival rates as applied to cancer of the breast. Metastasis 40 years or more after operation has been known to occur. Dymarski[4] from the Institute of Oncology at Leningrad reports 12 cases where metastasis occurred 11 to 21 years after surgery. However, Lavigne[5] in a study of 682 cases of recurrence found 85 per cent of recurrence to take place in the first five years. He found the percentage of recurrence after eight years to be negligible.

The use of irradiation for localized recurrences or localized metastases seems to be uncontested as the desirable first treatment. There is an occasional article that argues for the value of preoperative irradiation but the general consensus is against this. Hoffman[6] et als conclude from their review that no specifically proven effect on survival statistics is to be deduced from reports of preoperative irradiation. The consensus also seems to be that postoperative irradiation should be given only if a secondary area has been proven to be involved or if an unsampled area is thought to contain tumor. Paterson and Russell[7] from the Holt Radium Institute of Manchester, England, found irradiation good for the prevention of local recurrences but no more effective than treatment after recurrences have appeared. They found postoperative irradiation to have no effect on survival statistics. This latter conclusion is contrary to widely held opinion in this country.

Although the use of irradiation for recurrence is considered as only palliative treatment, the proponents of pre and post operative irradiation use these methods to enhance the cure rate. Two other procedures are also used to enhance cure rate. One of these, an old one is prophylactic castration. Treves,[8] in 1957, after a study of 109 patients who had been prophylactically castrated concluded that castration delayed the recurrence rather than effected a cure. He was not sure if castration should be done prophylactically or delayed until recurrence had taken place. Trimble and Trimble[9] in 1962, recommended prophylactic castration in any patient under the age of 30, whether or not there are axillary metastasis. They further recommend castration in all patients operated upon up to five years after menopause if there are axillary metastases. They emphasize that estrogens should not be used after castration and add that neither should phenothiazine derivatives be used for long periods since they stimulate breast tissue. Castration may be by surgery or irradiation with advantages and disadvantages associated with both procedures. Thyroid medication used prophylactically as suggested by the British gynecologist, Loeser, would come in this category of adjuvant methods to increase cure rates from radical mastectomy.

Besides preoperative and postoperative irradiation and hormone therapy including castration, a third and newer method has been proposed to enhance the cure rate of breast cancer. This is prophylactic chemotherapy. The rationale for this rests on the finding by several investigators of showers of cancer cells in the blood stream after surgery and other manipulation of the breast. Roberts[10] in studying cancer in general with follow up of two to five years, found the survival rate to be 50 per cent (38 per cent

as compared to 20 per cent) higher in those cases in which no circulating tumor cells were found during surgery. Moore and Stiver,[11] in a nationwide study of the use of Thiotepa in various University and Veteran Administration hospitals, in a follow up period covering 26 months, were somewhat optimistic as to results obtained. There are those however, who discredit the significance of the circulating cancer cells and also discount the accuracy of the findings of these cells in the blood stream.

The discussion so far has been of the methods of treatment designed to cure cancer of the breast. We shall turn now to methods of treatment that admittedly are only for palliation. There are many of these. For clearness of thinking we should classify these also into three groups. They parallel the three groups discussed above. They are radiological, hormonal and chemical therapy. They are used in recurrent disease for palliation alone although conceivably they could very rarely result in a cure.

Irradiation as stated above is usually the first treatment used. Especially in bone does it appear to be the most effective. It can be, although it usually is not given simultaneously with hormone therapy. The primary aim of hormone therapy in the premenopausal or early menopausal woman is to get rid of estrogen. This may be by antagonizing estrogen directly with testosterone or by reducing estrogen by removing the ovary and/or the adrenal and/or the pituitary glands. A further way of suppressing estrogen production is the administration of testosterone or cortisone or prednisone which lessens the pituitary stimulation of these glands. Some have used these hormones with bilateral oophorectomy and have obtained good results.

Estrogens in high doses especially diethylstilbesterol have been used with good effect. The reason for this is not apparent unless this hormone is not equally as effective as estrogen in directly stimulating breast tissue but is effective in suppressing the pituitary hormone secretion especially so far as follicle stimulating hormone is concerned.

Chemotherapy has apparently been used as a last resort after all else has failed. Hoffman[6] et als in a review of the world literature considers thiotepa to be the drug most frequently used and the one used with the best results. This has been combined with testosterone because of the hemapoietic effect on the latter.

Palliative therapy has, on the whole, been disappointing but there have been cases of outstanding success with this.

SUMMARY: A small series of personal private cases have been analyzed.

Some of the problems concerned with both curative and palliative treatment have been briefly considered.

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Usefulness Of Gamma Globulin To Prevent Rubella Doubted

Serious doubt concerning the usefulness of gamma globulin as a means of preventing rubella (German measles) among pregnant women has been expressed by the American Academy of Pediatrics.

Two Committees—on the Control of Infectious Disease and on Congenital Malformations—in a joint statement advised physicians that they should make decisions and recommendations for the management of pregnant women exposed to German measles "on the assumption that there is still no firm evidence that immune globulin is effective in reducing the risk of congenital anomalies."

Noting that the 1963-1964 epidemic of rubella provoked the need for reviewing recommendations about the use of human immune globulin, the Committees said, "In the absence of definitive data to support or reject its use, physicians have continued to use it in the hope that a few malformations might be prevented. This creates an acute shortage of human immune globulin in epidemic years, a useless expense for families if it is not effective, and diverts the product from other diseases where it is of established value."

Recent experimental studies involving blood tests and virus isolation from patients injected with immune globulin and rubella virus "suggests that immune globulin may suppress only the clinical manifestations of rubella without preventing the occurrence of infection or viremia," the Committees said. "It has not been established whether such viremia, in the absence of other manifestations of rubella in the first trimester of pregnancy, can be associated with fetal damage."

A Law That Curtails Progress

There is no doubt that the industry has been hurt by the Drug Amendments of 1962 and subsequent regulations . . . Ten major U. S. pharmaceutical firms have reported curtailment of research and development operations, and even those which report increased expenditures in these fields claim that they have had to cut back on the number of substances being investigated because of added costs and paperwork. We believe it is necessary, at long last, to challenge the steady erosion of our freedom by a regulatory agency; in effect to attempt to halt the steady descent of the pendulum.—C. Joseph Stetler, in *Cincinnati Journal of Medicine,* 45: 12, (Dec.) 1964.

Double-Blind Method— Short Cut to Nowhere?

The double-blind method is an expensive device (expensive in terms of the cost in effort and of the low yield of information) used in the hope—often the vain hope—of obtaining a quick answer to the simple question of a drug's effectiveness in restricted circumstances. It can be justified only as a means to be used by understaffed and overworked government agencies who have been given the impossible task (written into law by well-meaning but ill-informed legislators) of stating which drugs are effective and which are not. In the evaluation of drugs, or of anything else in medicine, there is no substitute for extensive minute observations made closely, continuously, and for long periods under conditions as much like those of ordinary practice as possible.—M. D. Altschule, M. D., in *Medical Science,* 15: 12, (Dec.) 1964.

Essential Hypertension* Clinical Experience With A New Combination Of Reserpine-Thiazide

F. Bernard Schultz, M. D. F. A. C. C.**

Auburn, Alabama

The past two decades have brought a number of advances in both the theory and management of hypertension. Despite intensive work in this field, there remain many questions yet to be resolved.

Experts continue to hold opposing viewpoints on the management of the hypertensive patient. The selection of patients who should be treated must take into account a number of variables including the degree of blood pressure elevation, evidence of existing vascular changes, symptoms, and emotional factors which may influence the disease. While there are undoubtedly those patients with significantly elevated diastolic blood pressures who will live to the normal life expectancy without treatment, such blood pressures can be shown statistically to decrease the life span.

There are many possible approaches to the management of the hypertensive patient and the appropriate measures will depend on the individual case. Diet and relief of symptoms may suffice for some. Control of emotional factors may be helpful. For others, specific drug therapy to control blood pressure may be indicated.

Numerous antihypertensive agents have been introduced including the *Rauwolfia* derivatives, ganglionic and sympathetic blocking agents, hydralazine, guanethidine, and the thiazide diuretics. These agents differ not only in potency and mechanism of action but also with respect to the nature and severity of side effects which they produce. Combined with the older methods of medical management of hypertensive patients, these agents provide the practitioner with a wide variety of approaches, some suitable for the milder forms of hypertension, others for the more severe. In selecting suitable therapy for hypertensives, the rational approach suggests the use of mild treatment for mild forms of hypertension.[1]

In order to reduce unpleasant side effects of some of the antihypertensive agents and to further enlarge the therapeutic armamentarium for hypertension, a number of combinations have become available. The author has previously reported[2] his observations on the diuretic and antihypertensive properties of benzthiazide (Exna,® Robins). The present report is based on a subsequent study of a new combination containing 50 mg benzthiazide and 0.125 mg reserpine*.

Method of Study

Fifty patients (ranging in age from 32 to 82 years) with essential hypertension were selected for inclusion in the study. Thirty-seven were women and 13 were men. Only

*This paper was presented in part at the National Convention in Los Angeles before the National meeting of the American College of Cardiology.

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*Reserclex®, A. H. Robins Co., Inc., Richmond, Virginia.

those patients with systolic pressures above 150 and/or diastolic pressures over 90 mmHg were included. All medication except digitalis preparations was discontinued. One week later, *control* blood pressure readings were taken with the patient at rest, eye grounds were examined, and particular attention was given to the character of the apical impulse and heart sounds. Hepatic enlargement and indications of peripheral edema were noted. Laboratory studies included a hemoglobin and urinalysis.

Each patient was given a supply of capsules containing 50 mg benzthiazide and 0.125 mg reserpine with instructions to take one capsule daily after breakfast. Specific dietary instructions were not given except to frankly obese patients who were advised to reduce their intake of fats and sweets. Since only enough medication was supplied to last one week, patients returned regularly for re-examination. Each was carefully questioned regarding his general feeling of well being, undesirable drug effects, changes in urinary output and other indications of drug action. After the first week, the dose for one patient whose initial blood pressure was 222/114 was increased to two capsules daily because of a poor response to the lower dosage. Another patient whose initial blood pressure was 246/170 was started on two capsules daily. A subsequent trial on the lower dosage failed to control the blood pressure and he was returned to the larger dose.

All patients (except one who died) were followed for a period of at least five weeks. Twenty-five were still under treatment and careful supervision at the end of ten weeks, and 23 were followed for as long as 15 weeks or more.

All patients were managed on an out-patient basis and were subject to the usual social and environmental factors. The patients were weighed at approximately the same time on each visit. A sphygmomanometer with a 13 centimeter cuff was used. The cuff was placed above the elbow and readings were recorded at the points where the sounds were first heard and where they abruptly diminished. All readings were taken by the author or his office nurse.

Results:

The average mean blood pressures (mean blood pressure = diastolic + ⅓ pulse pressure) at the initial visit and at the end of five, 10, and 15 + weeks were determined (Table 1). At the end of five weeks, the average mean blood pressure of the 49 patients still in the study was 106.1 mmHg, a decrease of 23.1 mmHg from the control average of 129.2 mmHg. At the 10 week interval the average mean blood pressure had risen to 111.8, and at the 15 + week interval it stood at 113.5. At this point in the study, the average mean blood pressure was still 15.7 mmHg below the control average.

Changes in body weight were noted at the five week interval. Analysis of these data revealed that 22 patients lost an average of 3.0 lbs., 22 patients gained an average of 2.1 lbs., and the weight of five patients remained stable.

There were no significant side effects that could be attributed to the test medication. One patient, a 62 year old woman, went into acute congestive heart failure two weeks after initiation of therapy and died. Until that time, her response was excellent and her blood pressure was under good control. Another patient, a 62 year old man, became extremely agitated and disoriented during the eighth week of the study. He was admitted to a state mental hospital for observation and died there five days later, presumably of acute mycardial insufficiency.

Although average values show trends and permit statistical comparisons, the response of individual patients is of interest. At the end of five weeks, the blood pressures of 48 patients were down, one was up, and one patient was dead. After 10 weeks, 25 patients were still in the study. Of the 25, the blood pressures of 22 were below control, one was unchanged and two were above control. After 15 weeks, 23 patients were still in the study. The blood pressures of 20 were still below control and three were above.

TABLE 1

Average mean blood pressure after 5, 10, and 15 + weeks of treatment with benzthiazide and reserpine

Weeks	Pts.	Av. Mean BP	Variation from Control	Variation from previous Mean
Control	50	129.2		
5	49	106.1	—23.1	—23.1
10	25	111.8	—17.4	+ 5.7
15+	23	113.5	—15.7	+ 1.7

Discussion:

The antihypertensive effects of reserpine and other *Rauwolfia* alkaloids are thought to be related to their ability to deplete body stores of catecholamines and serotonin from the brain, blood platelets, heart, arterial walls and other sites[3, 4, 5]. The central antihypertensive action of reserpine is probably a result of its tranquilizing properties. The theory of a direct effect on the vasomotor center has never been proven. Certain studies[6, 7, 8] in which reserpine failed to block the hypertensive effects of direct stimulation of the vasomotor center tend to discount this type of central action.

The antihypertensive effect of the thiazide diuretics results from two separate mechanisms of action. Initially, they bring about a diminution of the extracellular compartment of the body fluids through their diuretic action. However, since it has been shown that blood pressure does not rise again even when the extracellular compartment is restored with isotonic saline or glucose solution, it is now felt that the thiazides also have intrinsic antihypertensive properties unrelated to their effect on edema and body fluids.

The combination of two effective and synergistic agents represents a rational approach to the therapy of hypertension and may offer some advantage over a single agent. In the present study, the daily dose of 50mg benzthiazide and 0.125 mg reserpine lowered both the systolic and diastolic pressures and brought about an improvement of symptoms in all except two cases. When the daily dose was doubled in these cases, the systolic and diastolic pressures began to drop and no side effects were noted.

The lowering of blood pressure readings to more nearly normal levels was most marked during the first two weeks. Thereafter, there was a tendency for the mean blood pressures to slowly rise with the passage of time. Whether this was due to a slight tolerance to the combination of drugs or to an unwillingness of the patients to adhere to their regimen is debatable.

Reported side effects of reserpine include nasal stuffiness; gastritis, diarrhea, drowsiness, fluid retention, and depression. Since these side effects, and particularly depression, are insidious in onset, the clinician must maintain constant vigilance for early signs. None of these side effects was observed in the present study, perhaps due to the small dose of reserpine or the relatively small number of patients in the study.

Summary and Conclusions:

The antihypertensive effect of a combination of benzthiazide and reserpine was evaluated in 50 patients with essential hypertension. The patients were examined at weekly intervals for at least five weeks and intermittently thereafter for up to 19 weeks.

An excellent or good antihypertensive response was observed in 48 of the 50 patients during the first five weeks. The average mean blood pressure dropped from a control value to 129.2 mmHg to 106.1 mmHg during this period. During ensuing weeks there was a gradual rise in the mean blood pressure, but in only three of the 23 patients who remained in the study for 15 weeks or longer did the mean blood pressure rise above the premedication reading.

Weight loss during the first five weeks of study was not impressive. Although a satisfactory diuresis accompanied treatment with benzthiazide and reserpine, only 22 patients lost weight (an average of three lbs each). Twenty-two patients gained weight (an average of 2.1 lbs. each) and five neither gained nor lost. There were no significant side effects that could be attributed to the test medication. The combination of benzthiazide and reserpine used in this study would seem to be a safe and effective agent for use in the treatment of selected cases of essential hypertension.

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PATIENTS IN APPEALS CASES MAY SEE PENSIONS-SECURITY MEDICAL FORMS

Any information on medical forms used in the public assistance program by the Department of Pensions and Security must be made available to the patient in the event of an appeal hearing, Commissioner Ruben K. King reported today in a special release to the Alabama Medical Association.

"On certain forms, such as those for hospital claims and eligibility for aid to the disabled, a diagnosis and/or other medical information appears," King continued.

"We hold information on these and other forms to be entirely confidential, and never release it to the patient (assistance recipient) except in cases where there is an appeal hearing," King said. He added that since the inception of the hospital care programs there have been no appeals regarding claims, but wanted physicians to be aware of the situation should any be filed.

Mr. King said that if any forms are revised, efforts will be made to include on each a statement to the effect that the information thereon would be confidential unless an appeal occurred. Such statement already appears on the disability eligibility form.

"We recognize not only the confidentiality of the medical information, but also the desirability and right of the physician to disclose what he sees fit to the patient under normal circumstances," the Commissioner concluded, expressing deep appreciation to the Medical Association for the continued cooperation of its members with the Department of Pensions and Security in regard to the medical care programs.

Progress In the Study Of Rheumatic Diseases: Microscopic Analysis Of The Synovial Fluids*

Frank Lehn, M. D.**

Birmingham, Alabama

Termed the "most neglected differential test in arthritis" five years ago,[1] this appellation still unfortunately applies to analysis of the synovial fluid. In the five years since this pronouncement, the simple procedure of examining the synovial fluid under the microscope has assumed a role of even greater importance; a role that should never be neglected in the intelligent appraisal of a patient with arthritis. Three discoveries within this five-year period are responsible for this increased import and by themselves constitute a mandate to the physician to examine the joint fluid for diagnostic purposes.

The first of these discoveries occurred in 1961 when McCarty and Hollander[2] described the identification of urate crystals in the joint fluid of patients with gouty arthritis. These crystals were identified as short and rod-shaped with rounded ends and parallel sides, generally 0.5 to 25 u in length. In acute gouty arthritis, these crystals are mostly intracellular, while in chronic gouty effusions these crystals are mostly extracellular. Polarizing lenses may be purchased for a few cents that will convert any microscope to a polariscope and allow identification of brightly refractile crystals. A more positive identification can be made by use of a red-plate compensator to determine negative birefringence but in most instances the finding of crystals with hyperuricemia will be sufficient to make the diagnosis. An occasional patient may not be hyperuricemic for cases have been reported with normal serum uric acid levels.[3] It is also important to be aware that approximately 5 per cent of patients with gout will be clinically indistinguishable from rheumatoid arthritis.[3]

The second discovery occurred one year later when McCarty[4] and others described the finding of refractile crystals in joint fluids that were both rod-like and rhomboid in shape with many variable configurations in between. These crystals were identified as calcium pyrophosphate and their finding has been found to be definitive for the syndrome of pseudogout.[5] These, too, can be further identified by their positive birefringence with the use of a red-plate compensator, but the presence of refractile crystals with varying morphology should alert the physician to this diagnosis, particularly if characteristic X-ray signs are present.[5]

The last discovery is that of Hollander and others,[6] published recently, in which they describe the finding of inclusions in the leukocytes of rheumatoid synovial fluids. These inclusions are granular, 0.5 to 1.5 u in diameter and are found in the synovial fluid of 95 per cent of patients with rheumatoid arthritis. The "RA cells" containing these inclusions are predominantly polymorphonuclear, but may occasionally be monocytes. The percentage of cells containing these inclusions varies from three to 97, depending on the acuteness of the process.

Their similarity to "glitter cells" seen in the urine is striking, although the leukocytic granules of the synovial fluid usually do not exhibit the rapid motility seen in the urinary "glitter cells." These granules presumably represent phagocytized rheumatoid f a c t o r , and may be seen even though the patient does not have a positive serologic test for rheumatoid factor.

Other rheumatic diseases, including psoriatic arthritis, ankylosing spondylitis and

*This investigation was supported by Public Health Service Grants T1 AM 5000 and AM03555 from the National Institute of Arthritis and Metabolic Diseases and Merck Sharp and Dohme, West Point, Pennsylvania.

**From the Division of Rheumatic Diseases, Department of Medicine, University of Alabama Medical Center, Birmingham, Alabama.

juvenile rheumatoid arthritis, may occasionally exhibit these granules as well. The synovial fluid in pseudogout, traumatic arthritis and osteoarthritis also may rarely show intraleukocytic granules.

The microscopic examination of the synovial fluid is valuable in other entities. The presence of cartilage fibrils in joint fluid is commonly seen in osteoarthritis. A "cartilage count" of more than two per high-power field is extremely suggestive of this diagnosis,[7] particularly if the patient has not suffered recent trauma to the involved joint.

If lupus erythematosus is considered, the synovial fluid may be centrifuged and the cell "button" smeared and stained with Wright's stain. One may then look for in vivo LE cells which may be present.[7] If an infectious process is considered, appropriate staining techniques may reveal the causative organism.

In general, microscopic examination of the synovial fluid is an easily performed procedure that requires no particular expertise. The physician can easily identify crystals, fibrils and "RA cells" after seeing them only a few times. Microscopic examination of the joint fluid should then have the same importance that examination of the urine in renal disease or the peripheral smear in anemia has, and not retain any stigma as the "most neglected differential diagnostic test in arthritis."

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AMA Awards Additional Tobacco Research Grants

The American Medical Association Education and Research Foundation's Committee on Tobacco and Health has authorized the awarding of 15 new tobacco research grants.

The first-year grants for the new projects totaled more than $474,000. Length of the research programs range from one to five years and full commitment for the duration will total in excess of $1,280,000.

The Committee said these 15 additional grants bring to 43 the number of tobacco research projects AMA-ERF is currently giving financial support. The 43 programs have a total first-year commitment of approximately $1,500,000 and a five-year potential expenditure of over $3,600,000.

The grants are a part of a long-range research program on tobacco and health authorized in 1963 by the AMA House of Delegates.

Registry Of Tissue Reactions Established

Washington, D. C.—A Registry of Tissue Reactions to Drugs is being established here within the Armed Forces Institute of Pathology (AFIP) through the cooperation of the American Medical Association, the Pharmaceutical Manufacturers Association and the Food and Drug Administration.

The AFIP has the world's largest repository of pathological material for research and education, and the registry is expected to be a major addition to existing adverse drug reaction reporting programs.

"This unique cooperative effort for the benefit of the American public is the first between major drug manufacturing, drug prescribing and drug regulating bodies," said a joint statement issued by Dr. Jean Weston, Director of the AMA's Department of Drugs; Dr. Joseph Sadusk, FDA medical director, and Dr. Austin Smith, president of the PMA.

The purpose of the Registry will be to obtain autopsy or biopsy tissue specimens from suspected adverse drug reaction cases. These specimens will be thoroughly studied by all methods available to a full-time pathologist, including consultation with other authorities in pathology and toxicology. Results of the studies will be reported to local pathologists who furnished the study material, and monthly summary reports will be made to each of the three sponsoring organizations. Important information obtained will then be disseminated to the medical community. The pathological material will remain on file at the Registry for future reference and study.

The Tissue Registry will augment the existing drug reaction reporting programs maintained by the AMA and FDA. The FDA at present receives reports of suspected adverse drug reactions from about 500 cooperating federal and military hospitals, and from 110 civilian hospitals under contract.

The AMA receives such reports from physicians in private practice, a number of hospitals not reporting to FDA, and other sources.

Information is exchanged by the FDA and AMA, catalogued by data-processing techniques, and filed by data-processing machines. The data are then available for use in identifying drugs possibly associated with adverse reactions, in assisting physicians to diagnose possible adverse drug reactions, and in scientific investigations.

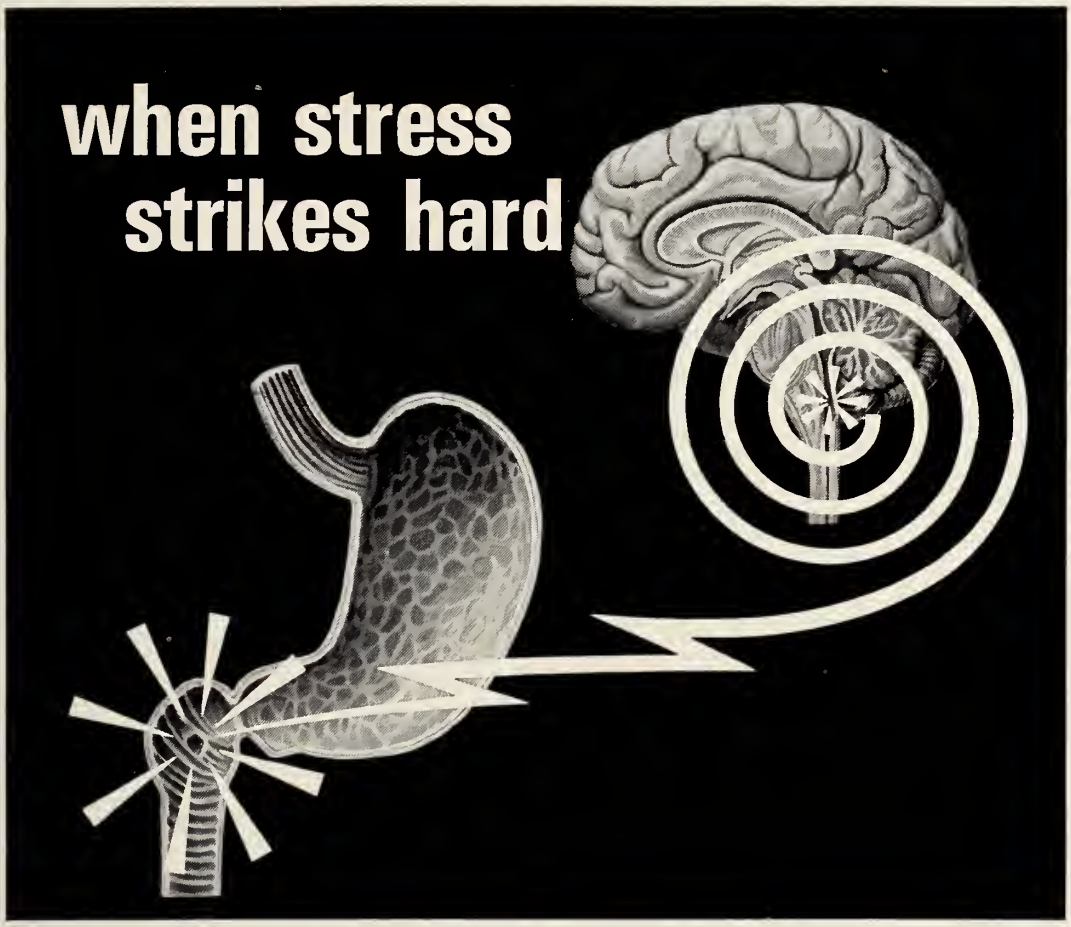
Establishment of the Tissue Registry was originally proposed by the Drug Research Board of the National Academy of Sciences-National Research Council. Twenty-eight such Registries already exist as joint activities of the Armed Forces Institute of Pathology and sponsoring professional societies. Collectively, the Registries are known as the American Registry of Pathology.

The parent Armed Forces Institute of Pathology, which is more than 100 years old, serves as a central laboratory of pathology for the Department of Defense and has become a center of research, teaching and consultation not only for the military but for civilian groups. AFIP offices and laboratories are in an eight-story building at Walter Reed Army Medical Center.

The cost of the Tissue Registry is being borne equally by each of the three sponsors. In its first full calendar year of operation (1966), the cost of operation and administration is expected to be about $100,000. The fund will be administered by the Universities Associated for Research and Education in Pathology, Inc.

Who Is Responsible For Drug Safety?

The wise, and presumably safe, use of a drug depends largely on the education, training, experience and judgement of the prescriber. And to an important extent it also depends on the wisdom of the patient as he follows instructions.—Austin Smith, M. D., in *Experimental Medicine and Surgery,* 22: 2-3, (June-Sept.) 1964.



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President's Page



One of the most significant actions of the Medical Association of the State of Alabama at its annual session in Birmingham in April, 1965, was the unanimous adoption of a new ordinance establishing a Board of Trustees. This Board of Trustees is created by the Board of Censors as a committee delegated with the responsibility of conducting the affairs of the Association. The unique situation in Alabama in which the entire Medical Association of the State of Alabama is the State Board of Health by law, requires that the Board of Censors continue to have the final legal authority to act for the Association when it is not in session. However, it is within the intent of the Constitution that the Board of Censors may delegate responsibility for conducting the affairs of the Association, and this they have done in approving the establishment of the Board of Trustees by the Association.

The new Board of Trustees will broadly represent the Medical Association of the State of Alabama, both geographically and officially. One member from each Congressional District shall be elected to serve on the Board of Trustees. This election is to take place at the meeting of the Counsellors and Delegates when they meet by Districts around noon on Friday of each annual session. For the first time the vice-presidents of the Association will have considerable responsibility in conducting the affairs of the Association. Each of them will be a member of the Board of Trustees. The President, President-Elect, immediate Past-President, and the Secretary-Treasurer will also have membership on this Board. Either the Chairman of the Board of Censors, or some other member of this Board, shall be an ex officio member of the Board of Trustees. One of the delegates to the American Medical Association shall also be on the Board of Trustees.

It will thus be seen that the Board of Trustees contains eighteen members, with the representative of the Board of Censors as an ex officio member. This will give broad representation from the Medical Association, with good liaison from the Board of Censors and from the American Medical Association Delegacy.

The Board of Trustees has been charged by the Board of Censors with the following duties:

I. To the Board of Trustees shall be referred without discussion: All motions, resolutions, or inquiries, of whatever nature, affecting the organization, policy or welfare of the Association, or of any one or more of the county societies in affiliation therewith;

All proposed amendments to the constitution, ordinances, or by-laws of the Association;

The message of the President delivered at the annual session and any recommendations he may submit to the Association at any called session;

All reports and recommendations of the Vice-Presidents submitted to the Association at any annual, or called session;

All questions involving the principles of

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ethics to which the Association has declared its allegiance;

The Board of Trustees of this Association shall receive regular progress reports and recommendations from the standing and special committees of the Association and shall recommend to the Board of Censors what action it deems necessary on these committee reports.

II. The Board of Trustees shall assume the duties of the Finance Committee;

The Board shall examine monthly and audit and accounts of the Secretary and Treasurer and report the same to the Association quarterly through the Board of Censors;

The Board of Trustees shall estimate the probable financial needs of the Association for the ensuing year and prepare an annual budget for the ordinary expenses of the Association and submit it to the Association for approval at the annual meeting;

III. The Board of Trustees shall have full responsibility for financing and assisting the President in programming of the annual meeting of the Association.

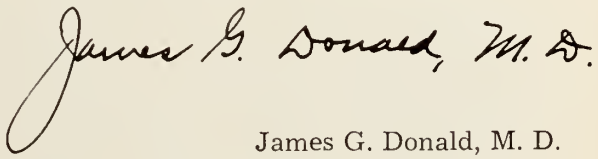
IV. The Board of Trustees shall appoint an editor of the Journal from its own membership, or from the Association.

V. The Board of Trustees shall furnish to the Executive Secretary those items to be included in the Handbook for Counsellors and Delegates prior to the first Monday in February.

VI. The Board of Trustees is to provide necessary office space, equipment and personnel to conduct the administrative affairs of the Association in a manner that will reflect credit to the Medical Association of the State of Alabama.

Since this new Board of Trustees will be the group primarily charged with these many important responsibilities in conducting the affairs of the Association, it is very important that every member of the Medical Association of the State of Alabama become personally acquainted with the member of the Board of Trustees who represents your Congressional District and with the Vice-President for your quadrant of the State of Alabama. In this way you will be directly represented on the Board of Trustees and your views can be made known to them.

We are fortunate to have the Board of Censors as the final legal authority for all actions of the Association when it is not in session. The many years of experience of the Board of Censors in conducting these affairs will be most helpful to the Board of Trustees in its deliberations and will certainly lead to action by the Board of Trustees in accordance with the previous policies and subject to the final approval of the Board of Censors. It is to be hoped that the Board of Trustees will function effectively to relieve the Board of Censors of the many detailed duties in connection with the affairs of the Association, leaving the Board of Censors more time for its many responsibilities as the State Committee of Public Health and the Board of Medical Examiners.



James G. Donald, M. D.

College Of Physicians Taps Six Alabamians

At the Golden Anniversary Session of the American College of Physicians held in Chicago, six staff members of the University of Alabama Hospitals and Clinics were named fellows. The Birmingham physicians who received this tribute are Richard C. Carter, M. D., Hugh J. Dempsey, M. D., H. Joseph Hughes, M. D., Bruce K. Johnson, M. D., Alwyn A. Shugerman, M. D., and Robert H. Yoe, M. D.

Dr. Ward Named Fellow By College Of Physicians

Dr. W. Q. Ward of Russellville, a member of the staff of the Memorial Clinic and North Alabama Hospital, has been elected to full fellowship in the American College of Physicians. The notification was made by the American Board of Internal Medicine.

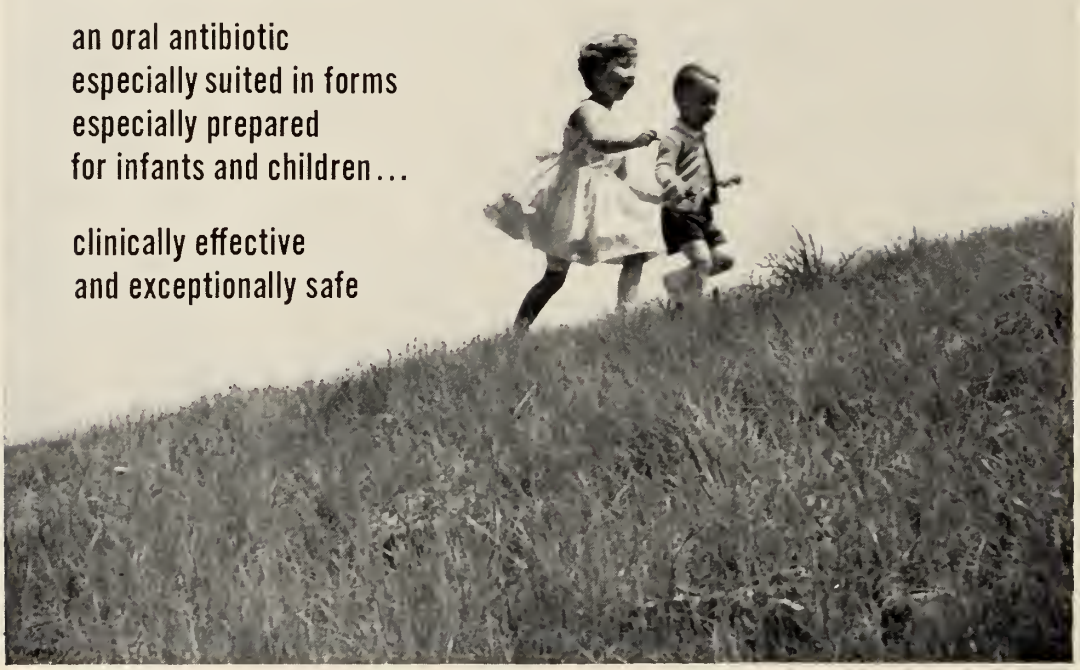
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Precautions: Side effects are relatively rare. Should a patient show signs of hypersensitivity, appropriate countermeasures (e.g., administration of epinephrine, steroids, etc.) should be employed and the drug withdrawn.

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*Done, A. K., in Drugs of Choice 1964-1965, Modell, W., ed., St. Louis, The C. V. Mosby Co., 1964, p. 66.

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The Medical Scholarship Act Of 1965

With a stroke of the pen, and without fanfare, Governor George C. Wallace signed into law the Medical Scholarship Act of 1965 on May 5, thus bringing into reality the most liberal and far-reaching measure ever enacted to overcome Alabama's critical shortage of doctors.

The foundation of the medical scholarship program was laid February 16, 1964, when the Committee on Medical Education and Hospitals heard a proposal by Dean S. Richardson Hill of the Medical College of Alabama to replace existing State Medical Scholarship and County Medical Scholarship plans with a single all-embracing dental-medical scholarship and loan program.

The committee voted unanimously to revise the program to meet existing conditions of pre-medical students and the Medical College and referred the matter to the Committee on Legislation for action.

"Alabama has one of the lowest population-ratios of physicians and dentists in the country," the Committee said in the preamble of its proposed program. "In a recent newsletter for the Medical Association of the State of Alabama, 78 towns were listed as seeking physicians; yet the need also exists in the cities. Each year outstanding prospective medical and dental students are lured out of the state by non-refundable scholarships; and good students from low income families are lost to these professions because of inadequate scholarship loan programs.

"Some attempt to improve or change existing programs is made with each session of the Legislature, but a satisfactory solution has not been reached. The existing county scholarship program has not met the needs of the state for either physicians or dentists. Many counties have no applicants for the scholarships, no satisfactory service repayment plans have been implemented, and the amount of the scholarship ($400) is too small to assure the education of good applicants from low-income families."

At the time Alabama had a scholarship program (Act No. 666 passed in 1953 and amended in 1959) providing for eight annual scholarships of $2,000 each with a maximum of $8,000 for four years to medical students matriculating for or enrolled in Medical College of Alabama. These scholarships were awarded annually to students selected by the State Board of Health in consultation with the Dean of the Medical College of Alabama. Each recipient of a scholarship under this Act entered into an agreement with the State Board of Health to practice medicine for five years after the completion of his medical training in an area or locality in the state designated by the State Board of Health.

Each year there were many more applicants for these scholarships than could be granted. It was recommended that the program be expanded not only to provide more scholarships for deserving young men and women but also to provide for better distribution of physicians into areas of the state deemed in need of them.

The committee pointed out that the primary purpose of the scholarship program was

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to keep doctors in Alabama; therefore, repayment plans should be flexible enough and broad enough for young physicians to meet with a degree of choice and satisfaction. "Alabama needs doctors and dentists," the committee continued, "but wants good doctors and dentists. Any financial aid should be based upon scholarship AND need. It should include some non-refundable aid based upon merit for its brightest young applicants. They will, then, not be attracted outside of the state by such aid from other sources.

"Other programs such as AMA-ERF loans and federal aid to education should be supplementary. These do not help the distribution of physicians and dentists within Alabama. They are not a substitute for a responsibility the state has for its own welfare and for the education of its own young people."

With these proposals at hand, the Committee on Legislation immediately went to work to draft a Medical Scholarship Bill for presentation to the Special Session of the Legislature which convened last February. The committee determined to go farther than the proposal they had received.

First it was decided that the 67 county scholarships of $400 each would be abolished since there were no specific requirements to qualify for these scholarships, no uniform scholastic or need requirement specified, and no implemented plan of repayment. Next it was determined that there should be 52 medical scholarship LOANS of $2,000 per year (the committee had recommended $1,500 per year) repayable either in cash or by serving in an area to be designated by the Board of Scholarship Awards.

There also were included eight annual merit scholarship AWARDS of $2,000 each based on scholastic achievement.

Later the committee added two annual scholarships of $5,000 each for any physician qualified to be licensed to practice medicine in Alabama who desired to pursue graduate training in public health provided he would obligate himself to become a county health officer, or an officer of the State Department of Public Health, for a stipulated period of time.

Thus was the request of the Committee on Medical Education and Hospitals fulfilled to devise legislation to:

(1) Attract exceptional students to the study of medicine;

(2) Provide financial aid for those not able to bear the expense of a professional education;

(3) Provide an increasing number of well-qualified physicians for service within the state of Alabama, and

(4) Provide physicians for areas where the need is now critical.

Two methods are provided for repayment of scholarship loans: The recipient may elect to repay them in cash over an eight-year period beginning one year after entering the practice of medicine or completion of specialty training, whichever occurs first, or he may elect to serve for four years in a community of less than 5,000 population deemed to be critically in need of additional medical practitioners or for five years in a community of 5,000-15,000 population, after which his loan would be considered repaid in full.

Should the recipient elect to practice in a community of more than 15,000 but less than 100,000 population, his loan obligation would be reduced one-half. He also could elect to practice for four years in a position in the Alabama Public Health Service or in any state institution approved by the Board of Medical Scholarship Awards.

Loans extended for postgraduate studies in the field of public health would be repaid by serving as a county health officer or an officer of the State Department of Public Health for a period of not less than three years.

Failure of a recipient to perform his agreement would constitute grounds for revocation

of his certificate of qualification to practice medicine.

To administer the program there was created a Board of Medical Scholarship Awards composed of the following: Two members of the Board of Censors for the Medical Association of the State of Alabama, the chairman of the Board of Trustees of the Medical Association of the State of Alabama, the Executive Officer of the State Board of Health, the Dean of the Medical College of Alabama or his designatee, the chairman of the Admissions Committee of the Medical College of Alabama, and two members appointed by the Governor for four-year terms, one of whom shall be a member of the State Senate and the other a member of the House of Representatives. Terms of all members except those appointed by the Governor are for one year.

It is significant that the medical scholarship bill passed both the House and the Senate without a single dissenting vote, an indication that the Legislators recognize the critical physician shortage which exists in Alabama today.

It may now be said that the Legislators have done their duty and the burden of implementing the scholarship law now rests to a large extent on the physicians of this state. It is incumbent upon each medical society and each individual physician to search diligently in his community for the qualified young men and the young women who are desirous of entering the medical profession. They should be informed of the new scholarship program and how we can help them to achieve their ambitions.

Upon the shoulders of our present physicians lies the responsibility for making certain that tomorrow's doctors shall not be deterred from their education by economic need or other considerations which, under the new medical scholarship bill may be eliminated.

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*Dorhout Mees,E.J.,and Geyskes, G.G.: Acta med.scandinav. 175:703,1964.

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Guest Editorial....

Report Of The President's Commission

Reprinted from the *New England Journal of Medicine*

The medical profession has a habit of greeting successive social changes with apprehension and then gradually adjusting to the realities of a new environment. It is at this moment passing through such a crisis. Perhaps for this reason relatively little attention has been paid the report of the President's Commission on Heart Disease, Cancer and Stroke, which proposes sweeping changes in the structure of American medicine. The medical community must carefully analyze the report and determine where it fits between two extremes—one the herald of a new standard of medical care, and the other a program that could in some ways fragment and weaken the present organization of medicine.

Yet when 28 commission members and a staff of 13 have labored for more than a year, as mentioned in the *Journal* on February 18, to analyze a complicated medicosocial problem, only the most incautious citizen would not receive their recommendations with attention and respect.

The report begins with the now familiar justifications—heart disease, cancer and stroke cause 71 per cent of all deaths. This statistic needs no emphasis. The gross national product is reduced because of these illnesses by $43,000,000,000 in direct costs and lost productivity. One can best accept this figure with the proverbial grain of salt.

The 35 recommendations include many with which there is no major disagreement. Increased financial support to medical schools is urgently needed, as is generally increased support for training of all health personnel. Incentive grants to stimulate community medical planning, increased public education on health matters, development of a National Medical Audiovisual Center and many procedural and structural changes suggested for various federal agencies can attract no debate. Nor, probably, will the proposal to flood more money into present medical-research programs, although it may be suggested that even now few well prepared researchers with a sensible project want for financial support. The difficulty is to find the people, not the money.

The major problem arises in the proposed national network of centers for patient care, research and teaching—a visionary plan that might with one stroke completely recast American medicine. The proposal, as is known, calls for 60 regional centers for clinical investigation, teaching and patient care for patients suffering from heart disease, cancer and stroke. Exactly how these units differ from hospitals is not clear, and through a strange oversight, their size is left entirely to the imagination. Presumably, at least 71 per cent of Americans would qualify for admission at one time or another, and would receive "bed support" while under investigation as part of their total care. (The reference is to free care, and not to shock blocks.) In addition, 450 "Diagnostic and Treatment Stations" would be established and staffed by experts to funnel patients toward the regional centers. A typical heart station would provide complete outpatient diagnostic and treatment facilities for any patient with heart disease. Hospital beds and emergency surgery would be available, and the stations would be open around the clock. These stations would become "self-supporting within a 10-15 year period."

The medical-care facilities in the United States have largely developed as an expression of local needs and have maintained a high level of emotional and financial support



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The most common side effects are nausea, edema and drug rash. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug.

Contraindications
These include: edema, hypertension, or danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when other potent chemotherapeutic agents are given concurrently because of the increased possibility of toxic reactions; when the patient cannot be seen regularly; when the patient is senile.

Note: The physician should be fully aware of dosage, precautions, side effects and contraindications as contained in the complete prescribing information.

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from the community. Only recently has the federal Government contributed significantly, and then with bricks and mortar as the Hill-Burton program, rather than in operation of the facilities. The national research and teaching effort has evolved around private and state medical schools and their associated hospitals. The federal Government has been to date an excellent partner in research, and has offered financial support to the institutions without fundamentally altering their operation. The commission report proposes a fundamental shift in this balance.

As stated above, the size of the newly proposed regional centers is not specified. If they are small and their activity is primarily directed toward research, they could be integrated into established organizations and have relatively little effect on the present flow of medical care. Perhaps this is the anticipated mode of operation. If so, the program is apparently designed largely as a way of infusing extra capital into clinical research, using the emotionalism surrounding heart disease and stroke as a means of achieving popular support. Nevertheless, even this laudable goal meets some reservations. The whole concept of program research is greeted less than enthusiastically by the scientific community. In a "program" approach the goal is set by the dollar sign, and not by factors such as the availability and interest of trained personnel, the relative scientific attractiveness of various research fields and the state of scientific development in these fields. With enough cash, research can be bought. This is apparent from the space programs. Rightly or wrongly, this has to date not been the primary approach in the health sciences.

However, academic medicine is supported by the public and bears a direct responsibility to it. Medical research must provide tangible benefits for today, as well as theoretical benefits for tomorrow. If in fact the nation's research effort has not been sufficiently oriented toward pressing medical and sociomedical problems, a "program" approach may be the necessary answer.

If the centers are realistically to provide care for people with the three conditions listed the facilities will necessarily be huge and may overshadow their associated medical centers. In addition to the problems associated with the scientific output mentioned above, the program will amount to federal entry in a big way into patient care, in a program lacking local support and responsibility, and in competition with pre-existing units. Has the public decided it wants the federal Government to operate a large portion of the medical facilities in the country? No consensus on this question is available.

The cost of building these centers and the problems of locating them will surely be enormous. Certainly, politics will not enter the equation, but how will a committee resolve the factors set into motion by establishing one university hospital—for example, in New York City—as a stroke center? Should the other hospitals close down their services? If not, how will they be able to compete financially?

The creation of specialized hospitals, which in fact the treatment centers are, runs against an important contemporary trend. More and more specialized units are now integrating with general hospitals to the benefit of each party. Specialized units are the glory of the empire builder and can be enormously successful. But if a specialty organization exists outside the general stimulation, supervision and criticism of a broadly oriented scientific environment, there is a tendency for inbreeding, and it often tends to run downhill. The problems apparent in the Cancer Chemotherapy Program may be taken as a case in point.

Is there proof that enlarged clinical-research units within the present framework of medical centers could not carry out augmented responsibilities? Is there reason to believe that 15 new special cardiac units would be better than strengthened units already present in every major teaching-hospital complex in the country—units that are

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AMA Bylaws

Chapter VI. Meetings-Section 2. Registration (A) Members. A Member's Section registration shall correspond with his specialty or General Practice status as designated by him for classification in the American Medical Association Directory. To be accepted for Section registration purposes, a member of a Section who desires to change his registration from one Section to another because of a change in his specialty, shall be required to inform the Headquarters of The American Medical Association by written notice of this intention at least *sixty* days in advance of the Annual Convention.

Chapter VII. Sections-Section 7. Participation in Business Only *active members* registered in accordance with Chapter VI, Section 2 (A) shall have the right to participate in the *business deliberation* of a section.

Please Note

An Active physician member may not *change his Section* registration for voting purposes from one Section to another Section, unless written notice of a change in his specialty has been given the AMA Headquarters at least 60 days (by April 20, 1965) in advance of the opening day of the Annual Convention.

Upon completion of an Active Member's Registration at the AMA Registration Desk, members will not be permitted to switch from one Section registration to another Section registration during the entire period that the AMA Annual Convention is in session.

However, all members are encouraged to attend any and all of the Scientific Section programs. Such attendance has no direct connection with the Section in which an Active Member may wish to be qualified to vote.

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- ☐ Anesthesiology
- ☐ Dermatology
- ☐ Diseases of the Chest
- ☐ Experimental Medicine and Therapeutics
- ☐ Gastroenterology
- ☐ General Practice
- ☐ General Surgery
- ☐ Internal Medicine
- ☐ Laryngology, Otology and Rhinology
- ☐ Military Medicine
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- ☐ Obstetrics and Gynecology
- ☐ Ophthalmology
- ☐ Orthopedic Surgery
- ☐ Pathology and Physiology
- ☐ Pediatrics
- ☐ Physical Medicine
- ☐ Preventive Medicine
- ☐ Proctology
- ☐ Radiology
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(Only Active Members Will Be Permitted To Vote)

fully integrated with the medical and surgical services of the hospital center?

Where will the staff for new institutions come from, when, as the Commission points out, a growing shortage of physicians already exists and little relief can be expected for five to ten years?

What happens to patients having some other illness? Should they be expected to pay taxes to care for patients with heart disease? Or will there be "other thirty per cent" regional centers?

Heart disease, cancer and stroke are serious problems, but should these illnesses be emphasized to the exclusion of problems more commonly striking down victims in the younger years?

It is also possible that the major deficit in present medical care is in the application of available information at the primary-care level, and not in the acquisition of new information. A distinguished physician once proposed a moratorium on research, and the idea contains a grain of common sense. It may be questioned whether the development of a complex of research centers will aid the family physician who is hindered already by too many patients, too many forms, too little time and a bewildering array of undigested medical facts. Will it provide the time or incentive or financial support for effective postgraduate education, and more importantly encourage translation of education into improved practice?

It is admittedly necessary to strengthen research, increase health personnel and plan regionally. It is less than certain that the whole fabric of medical care should be rewoven. The program must be carefully scrutinized by Congress, and by the nation's taxpayers. All things considered, the medical profession is in no position to stand alone and say "unfair," when its recent protestations have been so poorly received.

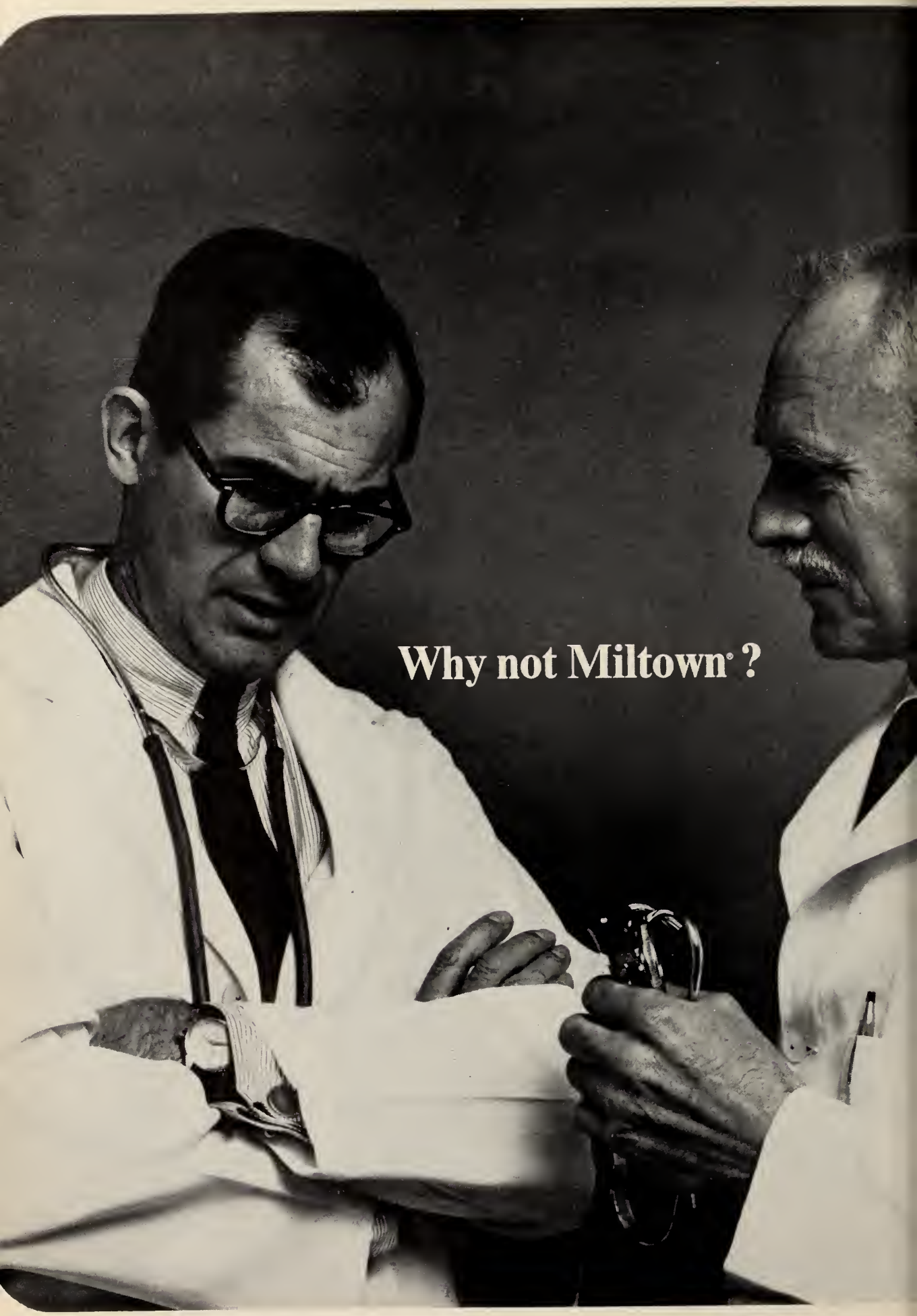
The line is already forming for the handouts since not many medical schools are going to be caught without at least one of the regional centers. In fact, the rush toward the public till may inhibit careful consideration of the program and its alternatives.

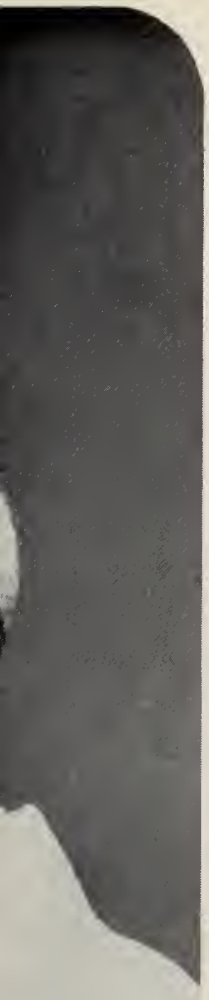


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Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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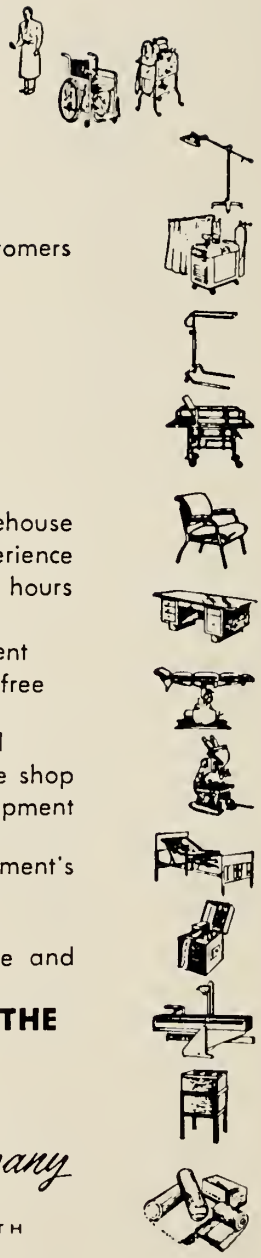
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Chenault Represents Alabama In Testimony Against Medicare

Dr. John M. Chenault of Decatur, member of the Board of Censors and Board of Trustees of the Medical Association of the State of Alabama, represented MASA recently in testimony against the so-called medicare bill before the Finance Committee of the U. S. Senate in Washington.

Dr. Chenault pointed out the many features of the proposal which he felt were not in the best interest of physicians or their patients and urged that the bill be defeated.

MASA president, Dr. James Donald of Mobile, Dr. Paul Burleson of Birmingham and Judge Newton Powell of Decatur also were in the delegation appearing at the hearing.

Dr. Chenault reported that the testimony of the medical profession was "well received" and that "we have some reason to hope that physicians can be excluded from the Social Security program."

He said that, during the questioning by Senator Anderson, "the point was forcibly made that no group had ever been taken into the Social Security system except on a voluntary basis."

U. S. Senator John Sparkman appeared before the committee with the Alabama delegation. "We were delighted to learn," Dr. Chenault added, "that he still favors the position of organized medicine concerning the objectionable features of H. R. 6675."

Hospital Shortage Cited By Huntsville's Jordan

The reason for a shortage of doctors in the Huntsville area is mainly lack of hospital beds, Dr. B. B. Jordan, president of the Madison County Medical Society, recently told a meeting of Young Republicans.

Dr. Jordan said there are 105 physicians in Huntsville serving 123,000 persons. The city has gained only one general practitioner in the past eight years and has only 10 pediatricians, none of which are taking new patients, Dr. Jordan pointed out.

Dr. Robert Oliver Speaks In Tuskegee

Dr. Robert K. Oliver, medical director of Tuscaloosa's Hale Memorial Hospital, recently addressed students at Macon Academy in Tuskegee on the perils of smoking. Dr. Oliver also addressed the Montgomery Tuberculosis Association on the same subject.







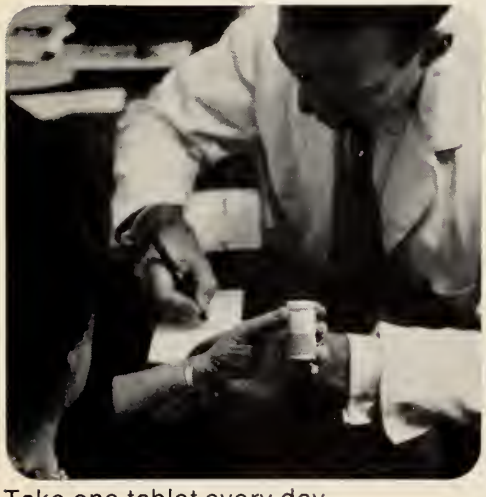




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*Chupkovich, V.; Finnerty, F. A., Jr., and Kakaviatos, N.: The value of chlorthalidone pl reserpine in moderately severe and severe hy tension: A two year study. Presented at the 7th Inter-American Congress of Cardiology, Montr June 14–19, 1964.

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Dr. Jean Clark MASA's First Lady Trustee

A lovely lady who also happens to practice medicine in Vincent, Ala. has become the first female member of the Board of Trustees of the Medical Association of Alabama.

She is Dr. Jean Clark who was elected to the previously all-male board at MASA's annual session in Birmingham last April.

Dr. Clark—she retains her maiden name for professional purposes—is married to another Shelby County physician, Dr. W. C. Browne. She is a member of the Alabama Chapter of the National Academy of General Practice, secretary-treasurer of the Shelby County Medical Society and is a past president of the Shelby society.

Dr. Clark also finds time to be a mother—she and Dr. Browne have three children—and to take part in the community affairs parenthood requires. She is active in PTA, Study Club, Federated Women's Club and other civic organizations in her community.

Dr. Clark was born in Neola, Iowa and received her medical degree from the University of Nebraska Medical School in 1942. While at Nebraska she received a fellowship in bacteriology during which she did experimental work.

Dr. Clark interned at Charity Hospital in New Orleans and in 1942 was granted a residency in obstetrics and gynecology on the Tulane Service. She was the first woman in medicine to receive this honor from Tulane.

Drs. Clark and Browne were married in 1943 and shortly thereafter Dr. Browne entered the armed services. Dr. Clark resigned her residency appointment in order to accompany her husband, but returned to Charity Hospital to complete her internship in 1946.

In December 1946, her internship completed, Dr. Clark rejoined her husband who had begun practice in Vincent. The two have been partners ever since.



DR. JEAN CLARK

How does she feel about being our first woman trustee?

"I look forward with enthusiasm to the responsibility of being a member of the Board of Trustees," Dr. Clark says, "and shall make every effort to justify the confidence that has been placed in me. I appreciate this opportunity to be of service, and, to say the least, I am truly honored."

Dr. Calix Resigns Post At Tuberculosis Hospital

Dr. Arthur A. Calix, medical director and superintendent of the District One Tuberculosis Sanitarium for the past 11 years, has resigned to enter the private practice of internal medicine in Decatur.

Dr. Calix's resignation is effective September 1.



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Matthew McNulty Receives Rare Honor

Leadership in scientific management of hospitals by Matthew F. McNulty, Jr., of Birmingham was recognized Wednesday afternoon, May 12, in Chicago by the Hospital Management Systems Society.

McNulty, General Director of the University of Alabama Hospitals and Clinics, was elected unanimously as an Honorary Member of the Hospital Management Systems Society. An official of the organization indicated that selection of McNulty marked only one of a very few honorary membership awards by the organization.

In making the award at the National Convention Annual Meeting, the President of the Society indicated, "This class of membership is bestowed only infrequently on persons of national stature who have made significant countrywide contributions to the advance of hospital systems through scientific endeavor."

McNulty has provided leadership for many years, innovating and encouraging methods improvement in hospitals. He is former Chairman of the American Hospital Association National Committee on Methods Improvement. He has served as a member of the National Advisory Committee to Hospital Systems Research at the University of Pittsburgh and the Georgia Institute of Technology.

McNulty has worked on various national methods improvement projects, including participation on programs with Dr. Lillian M. Gilbreath, wife and professional partner of Frank B. Gilbreath. It was Dr. Frank Gilbreath who, about the turn of the century, was the first scientific management consultant to apply motion study techniques to the hospital study situation.

Many other honors have been awarded McNulty. He is a past member of the Advisory Committee to the Hospital Division of the W. K. Kellogg Foundation. He has twice served as a member of the Advisory Committee to the Surgeon General on Professional Nurse Traineeship programs. He is a former member of the Advisory Board of the American Hospital Education and Research Foundation. He is a Fellow of the American Public Health Association and has served that organization in various local, regional and national assignments.

As a former member of the Board of the American College of Hospital Administrators, McNulty was the Regent for the six Southeastern states. He is past president of many health services and health science associations, including the Birmingham Regional Hospital Council, the Alabama Hospital Association, and the Visiting Nurse Association of Jefferson County.

At present McNulty is Chairman of the Teaching Hospital Section of the Association of American Medical Colleges. He is Chairman of the Committee for Health Science Libraries of the American Hospital Association and a member also of the Council on Nursing for the A. H. A. He is Vice Chairman of the Central Committee on Institutes which establishes policy for continuing education programs in the United States and Canada for the American College of Hospital Administrators.

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Three Alabama Doctors Receive Cancer Grants

Three Birmingham doctors have received grants from the American Cancer Society for research on the possible cure and prevention of the disease.

Dr. J. D. Emerson of the University Medical Center received a grant of $18,966 to study cancer immuno-therapy; Dr. William Niedermeier of the Medical Center received a grant of $17,288 to study certain aspects of mesotheliomas, and Dr. L. L. Bennett Jr. of Southern Research Institute was awarded a $28,550 grant to study the mechanisms of action of compounds which are known to inhibit the growth of tumor cells.

Epilepsy Foundation Seeks Birmingham Chapter

Plans are underway for the formation of a Birmingham chapter of the national Epilepsy Foundation, a non-profit organization supported by voluntary contributions.

The division of neurology of the Medical College of Alabama recently received a $6,000 initial grant from the foundation to finance such a chapter which could utilize the University Computer Center. The project was originated by Dr. Samuel C. Little, professor of neurology and executive officer of the neurology division.

Dr. Raymond Gasser Speaks To Academy

Dr. Raymond F. Gasser of the University Medical Center recently addressed the 42nd annual Alabama Academy of Science, held at Florence State College. Dr. Gasser's subject was "A Description of the Development of the Facial Muscles in Man."

Dr. Moore Addresses Luverne Rotarians

Dr. Morgan Moore of Andalusia recently was guest speaker at the Luverne Rotary Club. Dr. Moore's subject was the Elder-care-Medicare struggle now pending in Congress.

SOCIAL WORKER SCHOOL SET UP BY LAWMAKERS

A bill which would provide a graduate school of social work at the University of Alabama with money coming from the Special Education Trust Fund was passed by the recent special session of the Alabama legislature.

Sponsors of the law said a shortage of social workers in the state was acute and emphasized that health clinics must be adequately staffed to receive federal grants.

Among the leading supporters of the bill was Dr. William Tragle, director of the State Health Department's division of mental health planning.

Dr. H. S. Bartlett Named To Head State Surgeons

Dr. H. S. Bartlett of Montgomery has been named president of the Alabama section of the International College of Surgeons.

Other officers elected at the group's annual meeting in Birmingham recently were Dr. Albert Jackson, Tuscaloosa, president-elect; Dr. E. N. Kaiser, Montgomery, first vice president; Dr. B. F. Thomas, Auburn, second vice president; Dr. William Thuss, Birmingham, third vice president; Dr. W. H. Irwin, Leeds, fourth vice president; and Dr. Paul W. Shannon, Birmingham, secretary-treasurer.

Medical College Receives $47 Thousand From H. E. W.

The Medical College of Alabama has received a $47,032 federal capital contribution for the fiscal year 1966 under the Health Professions Student Loan Program. The grant was announced recently by the Department of Health, Education and Welfare.

The money, made available through the Public Health Service, is used for loans to full-time students who are pursuing a course of study leading to a doctor's degree.

FAMOUS ALABAMA PHYSICIANS

DR. J. MARION SIMS (1813-1883), who became one of the most renowned surgeons of his day, descended from rural stock. His family had been successful farmers in Virginia and the Carolinas. Marion was born Jan. 25, 1813, at Hanging Rock, S. C.

His father had little formal education and, as is often the case, Marion was barely five when his father launched him on a scholastic career. He attended a number of schools, including Franklin Academy at Lancaster, S. C., and at his father's insistence included both Latin and Greek in his course of study. Marion later attended South Carolina's state college at Columbia where he graduated in 1832.

In 1834, Sims enrolled at Jefferson Medical College in Philadelphia and his career was greatly influenced by two of his instructors there, Dr. Granville Sharp Patterson and Dr. George McClellan. Sims graduated from Jefferson March 15, 1835.

Dr. Sims returned to his home town for a few months of relatively unsuccessful practice and then set out with his father on Oct. 13, 1835 for Marengo County, Ala. Three weeks later they stopped in Mount Meigs, Ala., near Montgomery, where they planned to visit some South Carolina friends who were residing in the area. His friends persuaded Dr. Sims to remain in Mount Meigs and he began practice there late in 1835.

In 1840 Dr. Sims moved to Montgomery and, despite frequent attacks of malaria, acquired an excellent practice among the city's wealthy citizens. It was at this time that he encountered a case of retroversion of the uterus, and in the course of treatment he conceived of a method of observing the condition known as vesico-vaginal fistula.

While attending three Negresses who had been referred to him, and who were being treated in the private hospital which he had built in his yard for Negro surgical patients, Dr. Sims developed an operation which cured the condition.

Despite the fact that Dr. Sims considered himself a family practitioner and a surgeon, and usually had nothing to do with diseases of women, Dr. Sims became renowned for developing this operation. He moved to New York where he demonstrated his operation for vesico-vaginal fistula to doctors there. As soon as the New Yorkers learned to perform the operation, however, they dropped Dr. Sims who soon found himself without friends and almost without a livelihood.



Dr. Sims made an effort to interest doctors in New York in establishing a women's hospital, but he failed to gain their support. A series of meetings with influential women of the city followed which resulted in the opening of a 30-bed charity hospital for women May 1, 1855. Dr. Sims was surgeon. Later he became Chief Consulting Surgeon and a member of the hospital's board of governors.

During the summer of 1861, Dr. Sims toured Europe where leading surgeons had invited him to demonstrate the operation which he perfected. He returned to the U. S. and in 1875 was elected president of the American Medical Association.

Dr. Sims died Nov. 13, 1883. Statues of him have been placed on the capitol grounds at both Columbia, S. C., and Montgomery as well as in Bryant Park, New York City. When the Alabama Hall of Fame was inaugurated in 1854, Dr. Sims was one of the 11 persons originally selected for membership.

One of a series of Famous Alabama Physicians based on research compiled by Dr. E. B. Carmichael for

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Ronald Gene Owens, 16-year-old Sylacauga student, was presented one of two top citations of the AMA at the annual Health Awards dinner dance held at St. Louis during the National Science Fair-International. Young Owens, left, is shown above with Dr. Donovan Ward, AMA president. Owens' winning exhibit was entitled, "Mental and Physical Effects of Acceleration on Mice" and won him an expense-paid trip to the AMA's 114th annual convention in New York this month.

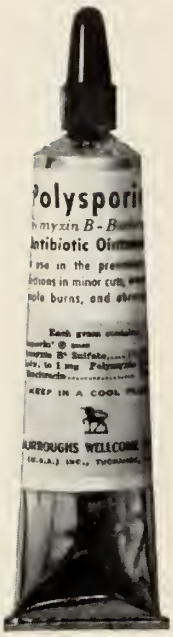
Dr. Cooper Opens New Clinic At Elba

Dr. Bancroft Cooper of Elba recently opened a new medical clinic at Elba in the vicinity of the Elba General Hospital. A large crowd attended a formal opening and inspection of the facility.

Dr. E. W. Stevenson Joins Staff At Norwood Clinic

Dr. E. W. Stevenson, formerly of Decatur, has joined the staff of the Norwood Clinic at Birmingham. Dr. Stevenson practiced as an ear, nose and throat specialist in Decatur for five years before moving to Birmingham.

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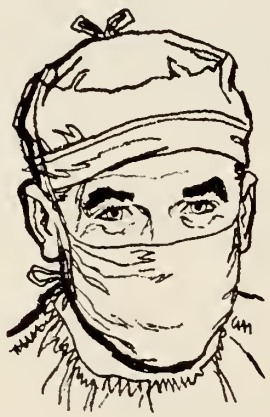
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Medical Assistants Plan Montgomery Seminar

Medical assistants from throughout Alabama will gather in Montgomery July 31 and Aug. 1 for their fourth annual seminar. Dr. James G. Donald of Mobile, president of the Medical Association of the State of Alabama, and Dr. Ira Myers of Montgomery, state health officer, will be featured speakers at the seminar dinner to be held Saturday evening, July 31. Dr. Donald will speak on "The Future Of Medicine In Alabama." Other program highlights follow:

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OBITUARIES

DR. FRANK R. WOOD

Dr. Frank R. Wood, 91, who had practiced medicine in Cleburne County for the past half-century, died April 21 at Cleburne County Hospital in Heflin. Dr. Wood was a graduate of Chattanooga Medical College and began practicing in Cleburne County in 1909. He was the county's first medical officer and served in that capacity for 17 years. Survivors include the widow, Mrs. Ressie Wood, one daughter, Mrs. E. C. Kirk of Roanoke; and three sons, Escar B. of Heflin, Frank P. of Jacksonville, Fla., and Will M. Wood of Roanoke.

DR. EDWARD WATERS GRAY

Dr. Edward Waters Gray, who had practiced medicine for more than 50 years, died April 4 in Florence at his residence. Dr. Gray was a 1909 graduate of the University of Alabama Medical School and served as president of both the Lauderdale and Colbert County Medical Societies. Survivors include a daughter, Mrs. Lawrence Traubue, of Nashville, Tenn.

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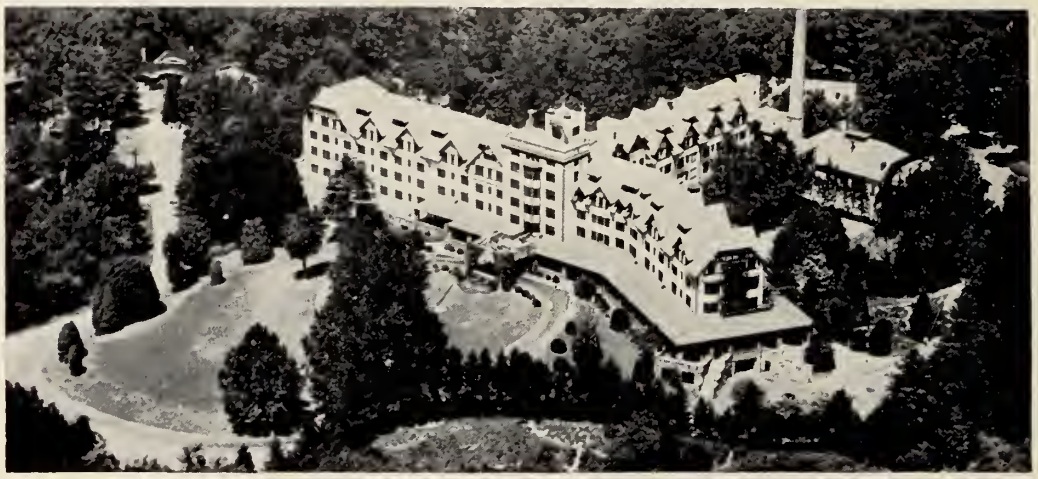
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The Woman's Auxiliary



Dear Doctors:

I would like for you to know who your "trademarks" are in our respective counties. Blount County is represented on the state board by having Mrs. Ira B. Patton as President-Elect and Mrs. W. R. Sutton as Parliamentarian. Cherokee County has our Northeast Vice-President, Mrs. Eugene Bradley, of Centre. Mrs. H. C. Johnson of Sheffield is serving as the Northwest Vice-President. Mobile County solicits your help in organizing other than the three counties which are organized in the Southwest District. Mrs. A. D. Henderson who is Vice-President of this district would like for you to encourage your wife to join our auxiliary. Will you please check to see if your county has a representative as an organized auxiliary or as a member-at-large! Covington County claims the Southeast Vice-President, Mrs. C. N. Matthews of Florala. She has eight unorganized counties in her district and needs your assistance and cooperation. This is an S. O. S. cry and you will agree with us when you hear that out of approximately 2,300 doctors we have a membership of only 1,354. PLEASE JOIN HANDS AND HELP US CLOSE THE GAP.

Our Revisions Chairman, Mrs. John Kimmey, of Elba represents Coffee County. Our immediate past president, Mrs. Lowell Clemmons, is to prepare the report forms and is from Cullman. The Disaster Preparedness Chairman, Mrs. George L. Andrews of Ozark, has already alerted Dale County in this project. Etowah County claims the Community Service Chairman, Mrs. T. M. Owens, of Attalla. The following chairmen are from Jefferson-Birmingham: Radio and Television, Mrs. William J. Rosser; Program, Mrs. William A. Cunningham; Southern Projects, Mrs. Gilder Wideman; and the counselor to the Woman's Auxiliary to the Student American Medical Association is Mrs. William Warrick. Our Historian, Mrs. Richard Dillard, and our Corresponding Secretary, Mrs. George H. Zenger, are both from Jefferson-Birmingham. Jefferson-Bessemer claims the following: Finance Officer, Mrs. J. P. Brooke; American Medical Association Education Research Foundation, Mrs. Ben H. Johnson; and Yearbook chairman, Mrs. Robert T. Cale. Lamar County is represented by Mrs. John R. Mize as Safety Chairman. Our Treasurer, Mrs. T. K. Lewis, Jr., of Decatur and Orientation Chairman, Mrs. John Chenault, are truly good trademarks of Morgan County. Pickens County claims our Recording Secretary, Mrs. R. K. Wilson of Aliceville. One of our members-at-large from Marengo County is Memorial Chairman, Mrs. Cecil E. Kimbrough of Linden. The following are from Mobile County: Legislation Chairman, Mrs. James K. V. Wilson; Health Careers, Mrs. Earl Wert; Archives and Exhibits, Mrs. James C. Barrett; Public Relations, Mrs. Dixon Meyers; Convention Chairman, Mrs. Curtis A. Smith, and her Co-Chairman is Mrs. Jack O. Yeager. The Editors of our Newsletter, Mrs. Harry J. Till and Mrs. W. L. Smith; and their typist, Mrs. Forrest Little, are doing an excellent job of publishing this communication in Montgomery. DeKalb County offers Mrs. William Noble of Fort Payne who is working on an Orientation Handbook. Shelby County is represented by Mrs. Lewis Kirkland of Monte-

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vallo who is Chairman of the Members-at-large. Tuscaloosa County offers two of our Chairmen, Mrs. James C. Guin, Jr. who is International Health Chairman; and Mrs. Sam Davis is serving as Mental Health Chairman. Our Rural Health Chairman, Mrs. John Rayfield of Sylacauga, has represented Talladega County as far away as Miami Beach when she attended the National Rural Health Conference.

Please offer these ladies words of encouragement and do not fail to call upon us during the coming year.

Sincerely,

Eloise B. Crenshaw

Convention Calendar

UNIVERSITY OF ALABAMA HOSPITALS AND CLINICS

June 12—Pathology and Pediatrics C. P. C. —9:00 a. m. to 10:00 a. m.—Room 112—Research Bldg.

June 15—Ob-Gyn Staff Meeting—4:30 p. m. —Fifth Floor, Old Hillman Bldg.

June 19—Pathology and Medicine C. P. C. —9:00 a. m. to 10:00 a. m.—Room 112—Research Bldg.

June 21—Orthopedic Surgery Staff Conference—5:30 p. m.—Crippled Childrens Hospital.

Every Monday—Anesthesia Chart Conference—3:00 p. m.—Fifth Floor—Old Hillman Bldg.

Every Wednesday—Cardiovascular Conference—4:00 p. m.—Room 725—Research Bldg.

Every Thursday—Pathology Department Staff Conference—12:00 noon—Room 623—Research Bldg.

Every Friday—Psychiatric Residents' Conference—9:00 a. m. to 11:00 a. m.—11 West —Grand Rounds—12:00 noon to 1:00 p. m.—Room 112—Research Bldg.

Every Saturday—Surgical Conference—8:00 a. m.—Room 112—Research Bldg.

POSTGRADUATE EDUCATION COURSE

(Hahnemann Medical College)

July 26-30, Hahnemann CVI Building, "Interpretation and Therapy of Cardiac Arrhythmias," Leonard S. Dreifus, M. D., director.

* * *

AMERICAN CANCER SOCIETY

(1965 Scientific Session)

June 16, Drake Hotel, Philadelphia, Pa. Course entitled "Hormones and Chemotherapy for Cancer—A Critical Appraisal."

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AMERICAN COLLEGE OF CHEST PHYSICIANS

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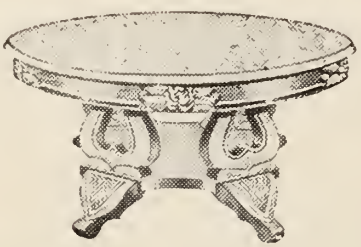
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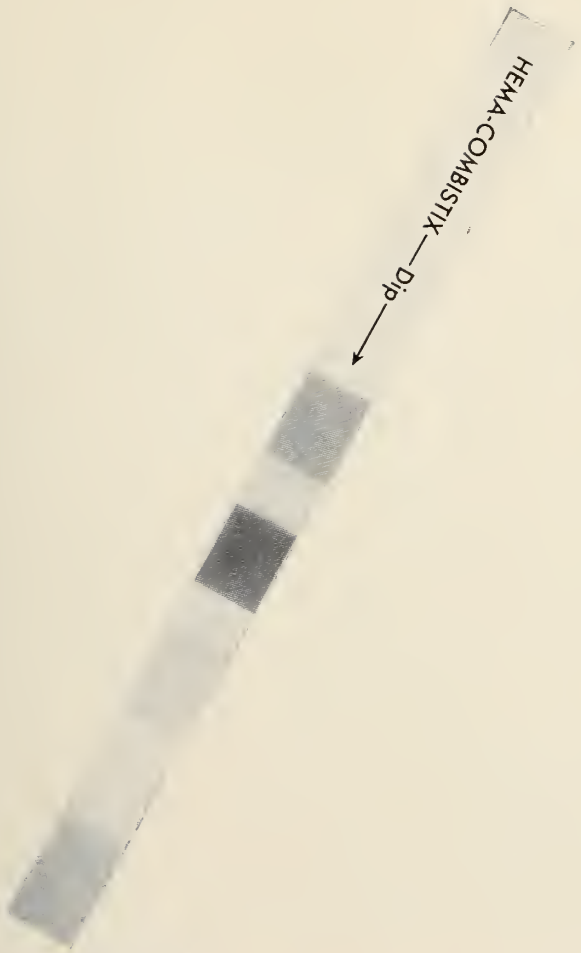


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